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ABSTRACT

Nationwide questionniare responses from hundreds of administrators constitute the data for this report. Schools must promote health, not only by teaching, but by being advocates of health, demonstrating that health is desirable and possible for all. After a prelude and background, the first chapter examines issues of health education, including underlying concepts, priority issues, definition, health and academic achievement relationships, and the federal role. Chapter 2 focuses on needs and goals on a national level, listing objectives and hazards. Chapter 3 looks at needs and goals locally, outlining goals for curriculum and administration. The fourth chapter examines management and health coordinators, advisory committees, and funding. Chapter 5 focuses on various curricula for health education uses. Chapter 6 looks at staff involvement and training, retraining, and utilization of learning resources. Chapter 7 relates reports from local communities nationwide. Chapter 8 investigates health services and the role of the school nurse. Chapter 9 discusses the role of parents in health programs. The 10th chapter examines the development of staff wellness. Chapter 11 deals with funding, budgeting, and the involvement of business and community groups. Finally, chapter 12 explores the assessment of health education and long-range evaluations. (WTH)

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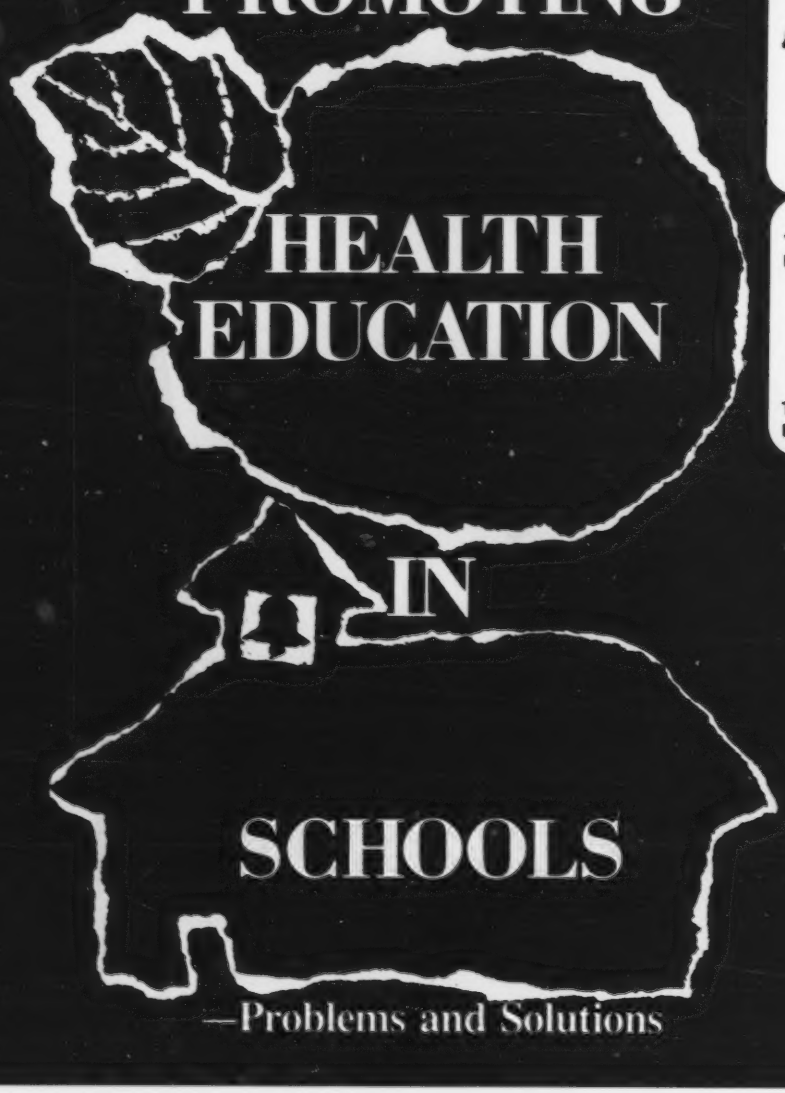

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American Association of School Administrators

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Critical Issues Report

PROMOTING HEALTH EDUCATION IN SCHOOLS

—Problems and Solutions

By Patricia Pine

American Association of School Administrators

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Contents

Prelude	Juvenal said it—John Locke repeated it—and for centuries before and after educators have pursued the goal of *mens sana in corpore sano*—Here we go again	*6*
Background	Origins of this AASA Critical Issues Report—government officials, health experts, and school administrators agree: there is a new type of health education and promotion—The survey and responses	*7*
Chapter 1	Issues What concepts underlie today's health education? Why give high priority to health education? What is health promotion? How healthy are today's children? Is there a relationship between health and achievement? What is the federal role?	*10*
Chapter 2	Needs/Goals National needs and national goals in health—Listing the objectives of 12 health topics—Hazards and risks to the nation and to students—How schools join in the great national prevention effort	*16*
Chapter 3	Local Needs/Local Goals How local school districts derive objectives for health promotion—Sources of local goals: national needs, community needs, student needs—Goals for curriculum and goals for administration	*23*
Chapter 4	Management Get your board policies and regulations in order—First tasks of leadership in health promotion—Health coordinators, school health, and community advisory committees—Time for instruction and money to pay for it—Managing for a healthful school environment	*25*
Chapter 5	Curriculum There are ready-to-use health curricula—There are homemade curricula—There are comprehensive health programs and programs for single topics—They deal not with facts alone but also with changing behavior	*31*
Chapter 6	Staff Competency for teaching health education topics depends on staff development, training, retraining—The health coordinator plays a role—So do community resources, colleges and universities, and students	*39*
Chapter 7	Action A casebook of action reports from a sampling of school districts—Experiences of administrators with community advisory groups, health coordinators, workshops for staff wellness—Reports from East, West, North, and South	*42*
Chapter 8	Health Services The school nurse is foremost in providing health services for students and staff—What the school nurse does and should do—Interview with a school nurse	*51*

Chapter 9	Parents Parental involvement in health education makes the difference—School and home are natural partners for the promotion of children's health—Parents, too, get the benefit of good school health programs	***55***
Chapter 10	Wellness Staff wellness, staff well-being, staff health: all an integral part of health education—Changing and improving behavior of teachers and other staff members—An interview with an authority on staff wellness	***57***
Chapter 11	Budget Paying for a modern comprehensive health program—What the regular school district budget can do—And how business, industry, professional, and civic groups can help	***61***
Chapter 12	Evaluation Assessing instructional efforts on behalf of student health—Long range evaluations and what they conclude—State of the art	***64***

The AASA Critical Issues Series

ven as new problems arise in education, the old ones persist. For both old and new, the search for solutions never ends. Solutions *do* emerge, even though they may not be ideal or the best single answers. For the better part of a decade, the American Association of School Administrators has identified educational problems and searched for solutions in a series of Critical Issues Reports.

PROMOTING HEALTH EDUCATION IN SCHOOLS is the 18th in this series. Educating for better health is an issue both old and new; old in that it has concerned schools for generations; and new in that medical and social sciences—and experiences in education—tell us that now schools can make an effective foray against poor health and for the promotion of a sound mind in a sound body.

The concepts for this report were first explored at a conference held at AASA headquarters early in 1985. Attending were Robert S. Gold, project director, School Health Initiative, Office of Disease Prevention and Health Promotion, U.S. Public Health Service, Washington, D.C.; B.E. (Buzz) Pruitt, executive director, Association for the Advancement of Health Education, Reston, Va.; and Len Tritsch, specialist, Health Education, Oregon Department of Education, Salem.

Representing the American Association of School Administrators were Effie Jones, associate executive director; Gary Marx, associate executive director, communications; Anne Dees, publications manager; and Ben Brodinsky, editor.

Participation by these individuals at the exploratory conference does not imply official endorsement of this book by the organizations they represent.

Promoting Health Education in Schools has been developed by AASA with the financial support of the U.S. Public Health Service, through the Office of Disease Prevention and Health Promotion. We extend our appreciation to its Director, J. Michael McGinnis, and Robert Gold for their assistance.

Our thanks go also to the hundreds of school administrators who responded to our request for help and ideas through a questionnaire mailed to school districts in all parts of the country.

The manuscript was written by Patricia Pine, an education writer in Washington, D.C. It was edited by Ben Brodinsky, editorial consultant based in Old Saybrook, Connecticut, and editor of AASA's Critical Issues Reports.

Richard D. Miller
Executive Director
AASA

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Associate Executive Director, AASA
Office of Communications

Prelude

Juvenal said it—John Locke repeated it—And for centuries before and after educators have pursued the goal of *mens sana in corpore sano*—Here we go again

Orandum est ut sit mens sana in corpore sano. (We should pray for a sound mind in a sound body.)

—**Juvenal** (c. 100 A.D.)

A sound mind in a sound body is a short but full description of a happy state in this world.

—**John Locke** (1693)

Strengthen the body before exercising the mind.

—**Jean Jacques Rousseau** (1762)

Concepts for health education–1776: Calamities, fluxes and fevers, spirits and other potions, victuals.

—**Anne E.** and **Bette Keyser**, in Health Education Forces and Factors Evolving Concepts (1976)

Concepts for health education–1865: Anatomy and physiology, mishaps and misfortunes, hygiene, home remedies and patent medicines, alcohol and tobacco, food and drink.

—**Health Education:** A Conceptual Approach to Curriculum Design (1976)

Make health an aim.

—**John Dewey** (1916)

The education and care of tubercular children and children of low physical vitality, while valuable, is but a small part of the health problem which a modern school system has within recent years been called upon to face. The discovery and isolation of bacteria; the vast amount of new knowledge which has come to us as to the transmission and possibilities for the elimination of many diseases; the spread of information as to sanitary science and preventive medicine; the change in emphasis in medical practice from curative to preventive and remedial . . . have all alike combined with modern humanitarianism and applied Christianity to make us take a new interest in child health.

—**Ellwood P. Cubberley** (1917)

To discharge the duties of life and to benefit from leisure, one must have good health. The health of the individual is essential also to the vitality of the race and to the defense of the Nation. Health education is therefore fundamental. . . .The commission therefore places health first with regards to the main objectives of education: 1. Health. 2. Command of fundamental processes. 3. Worthy home membership. 4. Vocation. 5. Citizenship. 6. Worthy use of leisure. 7. Ethical character.

—**The Cardinal Principles of Secondary Education** (1918)

To aim at health in a vague general way is scarcely to aim at all. We need an itemized statement of the specific habits which condition good health.

—**Franklin Bobbitt** (1920), as he proceeded to list 48 "health abilities" at which "education might aim"

"Teach Health, Not Disease."

—**Title of article in** *Health and Physical Education*, May 1941.

Background

Origins of this AASA Critical Issues Report—government officials, health experts, and school administrators agree: there is a new type of health education and promotion—The survey and responses

The call for a review of health education, addressed to school administrators, came most insistently from U.S. public health officials. They saw the mounting statistics on cancer, lung and heart disease, teenage pregnancies, youth stress, and suicide. At the same time they saw the accumulation of medical knowledge that could be used for prevention of sickness, low vitality, and the old and new ravages of body and mind.

It is urgent, these public health officials said, to call for participation of U.S. schools in efforts to apply the new knowledge and to transmit it to students, faculty, and families of the nation.

Health educators agreed but took pains to stress that there are also new ways to educate for health. They had seen some of the old ways fail—although there were still some indispensable ingredients in the traditional ways the schools go about to promote student health.

When the American Association of School Administrators accepted the call for developing a new report on health education, a first question to arise was: What are the characteristics of this new type of health education? Health specialists immediately stressed that it was not only a question of health *education* but health *promotion*. By this they meant the schools must not only teach, but also be advocates of health. They must demonstrate through staff behavior, through a safe school environment, through involving parents and the public, that health is desirable and possible for all.

Fourteen Points of Difference

Some of the traditional elements of health education are still with us in many districts, and some are good and indispensable, including such valuable work as early emphasis on dental care and efforts to identify children with poor vision, hearing problems, and malnutrition. At the same time, the new health curriculum is pushing for recognition.

The movement is from the old to the new, and the differences between the two are becoming sharply apparent. Here are 14 points of difference:

The Traditional School Health Program	The Emerging, New-Style School Health Program
1. Concentrated on student acquisition of facts about the body—its anatomy and physiology	Concentrates on inculcating habits and practices of healthful living; focuses on changing behavior
2. Saw the school and the classroom as the beginning and end of all health education	Takes the classroom to the community and the community into the classroom
3. Placed main responsibility for health instruction on the classroom teacher or school nurse	Seeks participation of doctors, health specialists, experts, and medical technicians as helpers to teachers in the instructional process
4. Used textbook as main source of information	Supplements textbooks with a wide range of instructional materials in print and technology
5. Paid little attention to coordination and comprehensiveness in health instruction. Curricula spotty; offerings often uneven	Seeks and develops comprehensive K-8 and 9-12 health curricula
6. Made little use of community resources	Makes contacts with hospitals, clinics, food establishments, police, fire protection, highway safety, and sanitation facilities
7. Lacked the characteristics of a challenging subject or discipline; often regarded by upper grade students as a snap course	Infuses courses of study with elements from biology, chemistry, nutrition, physiology, anatomy, human development, psychology, and other basic sciences
8. Concentrated on personal hygiene—to the exclusion of much else	Personal hygiene, yes. But prepares students also to be concerned about a safe and healthy community and to become wise consumers of health services

The Traditional School Health Program	The Emerging, New-Style School Health Program
9. Seldom used materials and resources of heart, lung, cancer, and other professional associations	Seeks out and uses the rich reservoirs of materials and other resources from health and medically oriented professional organizations
10. Saw little relationship between bodily health and scholastic achievement	Takes note of the mental vigor stemming from proper nutrition, rest, and exercise
11. Encouraged minimal parental involvement in promoting health of students	Parents are recognized as potent partners in the promotion efforts for healthy students
12. Often failed to recognize importance of adults—teachers, principals, parents—as role models; and of the influence of adult behavior on student health practices	Considers adult role models as a crucial ingredient in health promotion
13. Largely ignored health conditions and behavior of teachers and other school staff. Health education was mainly for students	Promotes staff wellness programs that, for example, seek elimination of smoking among faculty, promote bodily vigor, and inculcate proper eating habits
14. Failed to perceive the school environment as a factor in health education and as affecting student and staff health	Buildings and school grounds are kept clean and safe, free of toxic agents, as one means to promote health of students and staff

The Survey and Responses

How rapidly are school districts moving toward a changed and enhanced school health program? What progress are they making? What obstacles are they encountering?

To get answers to these and other questions, AASA mailed a questionnaire to a structured sampling of school administrators. The answers, received in early 1985, were enlightening. The evidence school administrators gave has been used throughout the chapters of this report. The gist and highlights of items developed more fully later in this report follow.

Gist and Highlights

Revising the curriculum: When administrators were asked to name their district's most important action on health promotion during the past 24 months, most pointed to curriculum changes. In Tahoma School District, Maple Valley, Washington, two actions were taken: a district-level committee has been formed to draw up a comprehensive curriculum, and staff have been trained for a new drug and alcohol education program. Officials in this district feel that the lack of a comprehensive curriculum has, in the past, been the district's most troublesome health education problem.

In Scottsbluff, Nebraska, curriculum revision is the main task at hand. Although the district already has a K–12 health curriculum guide, staff members are rewriting it.

In Willow Grove, Pennsylvania, administrators are revising the elementary school health education curriculum and, in the process, are looking over several health programs listed by the U.S. National Diffusion Network. In Oak Park, Illinois, a review of an elementary school health education curriculum adopted four years earlier is underway.

Training teachers: The 1985 priority in Steamboat Springs, Colorado, is preparing teachers for a new curriculum: assistant superintendent Cynthia Kaufmann is helping secondary level teachers incorporate the *Teenage Health Teaching Modules* (a program discussed in later chapters) into their classroom instruction, while elementary school teachers get used to a program called *Growing Healthy* (described in subsequent pages). At the secondary level, science and home economics teachers are being trained for the new curriculum.

Special topics: Other districts are concentrating on special health topics—placing a priority on alcohol or drug abuse education, child abuse assistance, suicide prevention, or sex education. William Savage of the Fairfax County (Virginia) Public Schools feels that his district's biggest step is adoption of a program sponsored by the Lions Club called "Quest." This program, for grades six through eight, is designed to help students develop responsibility for their health and equip them with skills they need to make decisions about health.

Advisory groups: A number of districts report changing district policy and forming advisory groups to improve health education. Lincoln A. DeMoura, assistant superintendent of schools, Taunton, Massachusetts, reports that a health advisory committee has been formed as a first step toward a comprehensive curriculum. The Parkway School District, Chesterfield, Missouri, has established a Wellness Advisory Board composed of administrators, nurses, counselors, parents, clergy, and law enforcement officials. Members meet to discuss health issues, while subcommittees on community support, employee assistance, curriculum, and other topics meet to plan ways to carry out the board's overall goals. During the past two years, Parkway has hired a health education consultant to work on the curriculum.

Health coordinators: Many administrators report that hiring a health coordinator has been their district's most significant recent action for health education. Both large and small districts are taking this step. In South Milwaukee, Wisconsin, for example, assistant superintendent Fred Klaisner thinks that putting a new health coordinator on the staff of this urban district solved the most serious problem there. In Buffalo, South Carolina, a newly hired health/science coordinator received similar acclaim.

Staff wellness: A few administrators also have launched staff wellness programs. In Starkville, Mississippi, Robert J. Garvue reports forming a health and physical fitness committee for this purpose. Among other things, the committee has taught cardio-pulmonary resuscitation to the entire district staff of 250.

Most Troublesome Problems

According to survey respondents, their biggest single worry is finding time to cover all the important health topics, especially with the current pressure to concentrate on basic academic skills. James E. Westbury, superintendent of the Normandy School District, St. Louis, Missouri, finds the problem especially difficult at the middle school level. Normandy administrators are re-evaluating time allotments and scheduling practices as they search for an answer.

Some administrators also reported having a hard time finding money and qualified staff for health education. James M. Pasquill, superintendent, Palmer, Massachusetts, hopes to address his staffing problems by increasing the number of hours that school nurses are available and by revising the physical education program to provide more structured time for health.

Other superintendents indicated that their biggest headache is controversy over health topics (sex education and drug education head the list of touchy subjects). In Union County, South Carolina, school officials were addressing a sex education controversy by drafting a new board of education statement that clearly spells out the district's official position. Other administrators were trying hard to work with parents to head off controversy.

A few survey respondents reported they were frustrated by the way that health is perceived in their schools. "Trying to get people to realize the importance of the subject and give us enough money and manpower to succeed" is a concern of Sallie Touhey of the Ithaca, New York, city schools. "I talk to anyone who will listen," she adds. A few districts also said they were having trouble getting more students interested in health education. William Young, superintendent in Union City, Pennsylvania, is helping teachers work up more challenging class activities, since students there failed to enroll in a high school health course.

Student Stress

By a large majority, administrators agreed that today's students carry a growing burden of stress. Administrators say that the growing incidence of emotional and academic problems, suicides, and antisocial behavior prove their point. "There is more acting out in nontraditional ways—alcohol, drugs, suicide, and sexual behavior," said Peter Hanly, director of pupil personnel services at Croton-Harmon School District, New York.

Administrators were divided about whether the schools or society are most to blame for increasing pressure on students. Some felt the schools were contributing to the problem by calling for higher standards and tougher grading. Most administrators, however, blamed a combination of factors, many of them arising beyond school walls. The stress "is being brought about by so many family problems, especially divorces and separations," said Emery Cathey, elementary principal in Emory, Texas. In most districts, according to the survey, administrators expect counselors to do the most to help students cope with stress.

Chapter 1

Issues

What concepts underlie today's health education? Why give high priority to health education? What is health promotion? How healthy are today's children? Is there a relation between health and achievement? What is the federal role?

Three concepts provide the basis for a new type of education to promote health for the children and youth of our nation:

1. What we eat, drink, inhale, and how we use our bodies will do more to prevent illnesses and keep us healthy than pills, wonder drugs, or the marvels of medicine. "Individual behavior is more powerful than all of the 20th century medicine," says William H. Foege, M.D., former director of the National Centers for Disease Control in Atlanta.
2. We choose the kind of health we will have with the habits and behavior we choose.
3. Good health habits and behavior can be taught and learned, provided we start with students at an early age and work with them continually and consistently using the full resources available to the schools.

"We have children in school for a substantial period of time and, given the opportunity, we can affect their knowledge, attitudes, and practices in health," says Robert S. Gold, U.S. public health official.

"Since there is no concerted effort to do this outside the schools, it's imperative that we do it in school. I'm not trying to make a case for the schools to take on everything that society needs to have done, but I do think it is of vital importance that we take on the challenge of health promotion at the time we can most effectively promote health—when the children are in school."

Why Give High Priority to Health Education?

Education pursues many goals. Periodically, the pursuit gets hot, as the community or pressure groups demand emphasis on reading, on mathematics, or on science. But cool-headed administrators always see the larger goal and see it steadily and whole. They do not lose sight of the timeless purpose of education and why it is supported with taxes: the preparation of students for successful, fulfilling, happy lives.

An individual's health is central to such a purpose. The schools cannot develop productive, self-sufficient citizens without strong programs of health education and health promotion.

More urgent and immediate reasons arise from conditions in today's life—conditions that touch every person, every home and family, every community in the U.S. Poor nutrition and faulty eating habits; students caught in the horrors of drugs and alcohol and in the consequences of smoking; students ravaged by high blood pressure, mental stress, and accidents; students victimized by ignorance about sexuality—these and other risks and hazards can be alleviated primarily within the schools through health promotion programs.

Instruction, school health services, and school environments conducive to health—that powerful trio—can help reduce the incidence and rate of death and disease of body and mind. The schools can help lift the heavy burden that society carries because of preventable illness and health malfunction.

The proven fact that healthy children learn better is a persuasive reason for many administrators to support health promotion programs. The research evidence is clear on this point. In the words of J. Michael McGinnis, deputy assistant U.S. secretary for health, "Health-related behaviors directly influence the cognitive performance of students and, consequently, educational achievement. Unless a child is alert, healthy, well-fed and fit, you cannot teach that child those subjects traditionally called basics."

Another pedagogical reason for administrative support of health is that students in modern health programs do not learn facts alone. They also are involved in learning critical thinking skills, problem solving, decision making, and in assuming personal responsibility for their own behaviors.

Such a cluster of learning experiences, part of health curricula, adds weight to reasons for full administrative support of health education. Health, as one educator said, is a basic of basics. Another view: Health programs have the full right to take place alongside other basic disciplines.

The administration that supports and maintains a continuous health promotion program will note in short time that student absenteeism is reduced (one superintendent reported that health education "has improved attendance by 10 percent during one recent year"). Teacher absenteeism, too, is likely to go down, as staff wellness programs begin to take effect. Staff morale goes up with good health. Accidents go down in a school environment that is sensitive to safety. And as an extra benefit, insurance rates for health-conscious school districts often decrease.

Finally, still another reason for supporting health promotion in schools is that such programs not only earn the

gratitude of parents but also get parents involved in developing courses and school-based health experiences. Health promotion efforts can also unify civic, community, and health-oriented volunteer associations. The superintendent who seeks help and cooperation from the community for the health of its children will frequently find help for educational achievement of students at all levels in all subjects.

But the ultimate reason for supporting health education can be stated in a composite of views expressed by a number of school superintendents, board members and principals: "It's good for the child, good for the family, good for the nation."

The Three Elements of Health Promotion

Health instruction, school health services, and a healthy school environment are the three ingredients in a modern health promotion program for maintaining, reinforcing, and enhancing the bodily and mental vigor of children and youth.

This three-part approach implies something quite different from what has traditionally passed as health education in schools. The old-time health education, as someone has quipped, meant pushups, perspiration, and slide shows on using cotton swabs. The new health promotion concentrates on teaching children the latest knowledge about ways to stay healthy and to avoid the risks of accidents, smoking, and mental stress, to name but three objectives. Health education in schools looks beyond the school years, offering concepts and insights for avoiding and mitigating the risks of many adulthood conditions—cardiovascular problems, arthritis, and others.

"Health promotion means enabling people to assume a greater role in their own health care," says the Education Commission of the States in its 1981 document, *Recommendations for School Education: A Handbook for State Policymakers*.

"Health promotion in school has as its goal self-motivated, self-care health activities on the part of students," says Elaine Brainerd, Connecticut State Department of Education.

Instruction—First Element

Instruction is the first element for reaching the goal of healthy students. But today's instruction for health covers many themes, many issues, many facts. Physical health is a main, but not the only, topic for instruction. Instruction also covers mental, social, and emotional health, and it is also concerned with consumer, community, and environmental health.

Consequently, health education is no longer the subject that many of today's school administrators encountered when they were in school—a subject that consisted of fragments of information tucked into biology, home economics, or physical education classes. "We're not selling old hat," says B.E. (Buzz) Pruitt, executive director of the Association for the Advancement of Health Education. "I wouldn't try to sell the old health education about bones and muscles and hygiene."

What, then, are the topics which schools and curricula deal with in a modern, comprehensive health education and promotion program?

Coming very close to a consensus, educators list them as follows:

- Personal health
- Mental and emotional health
- Prevention and control of disease
- Nutrition
- Substance use and abuse
- Community health
- Consumer health
- Environmental health
- Accident prevention/safety
- Family life education

Services—Second Element

True health promotion is more than what happens in the classroom. Just as important is whether a school provides the services to help prevent and control students' health problems and whether it has positive answers to such questions as:

- Does your school district employ school nurses and other specialists to screen pupils for vision and hearing problems and also for scoliosis (curvature of the spine) and high blood pressure?
- Does it help students appraise their own health risks?
- Has it spelled out plans for providing emergency services in case students are injured or become sick at school?
- Are health records on immunization kept up-to-date?
- Are teachers trained to spot the signs indicating that students have a health problem?
- Are the school nurse's teaching talents put to good use?

Environment—Third Element

"It's not just a matter of keeping a school building scrubbed clean," said one superintendent in commenting on the importance of environment.

Keeping a school clean is certainly a factor in the promotion of health among students, teachers, and other staff members. There are other factors:

- The struggle against asbestos is a struggle against a clear and present danger in many schools.
- Proper maintenance of buildings and grounds communicates a message to the school population and the public that, as one superintendent put it, "health and wellness are respected here. . . ."
- Safety regulations, safety inspection, and drills and patrols with pupil planning and participation are crucial in protecting the lives and well-being of students and staff.

• Strict adherence to legal regulations and standards for sanitation, lighting, heating, and ventilation are some of the means for health promotion in schools—and important ones.

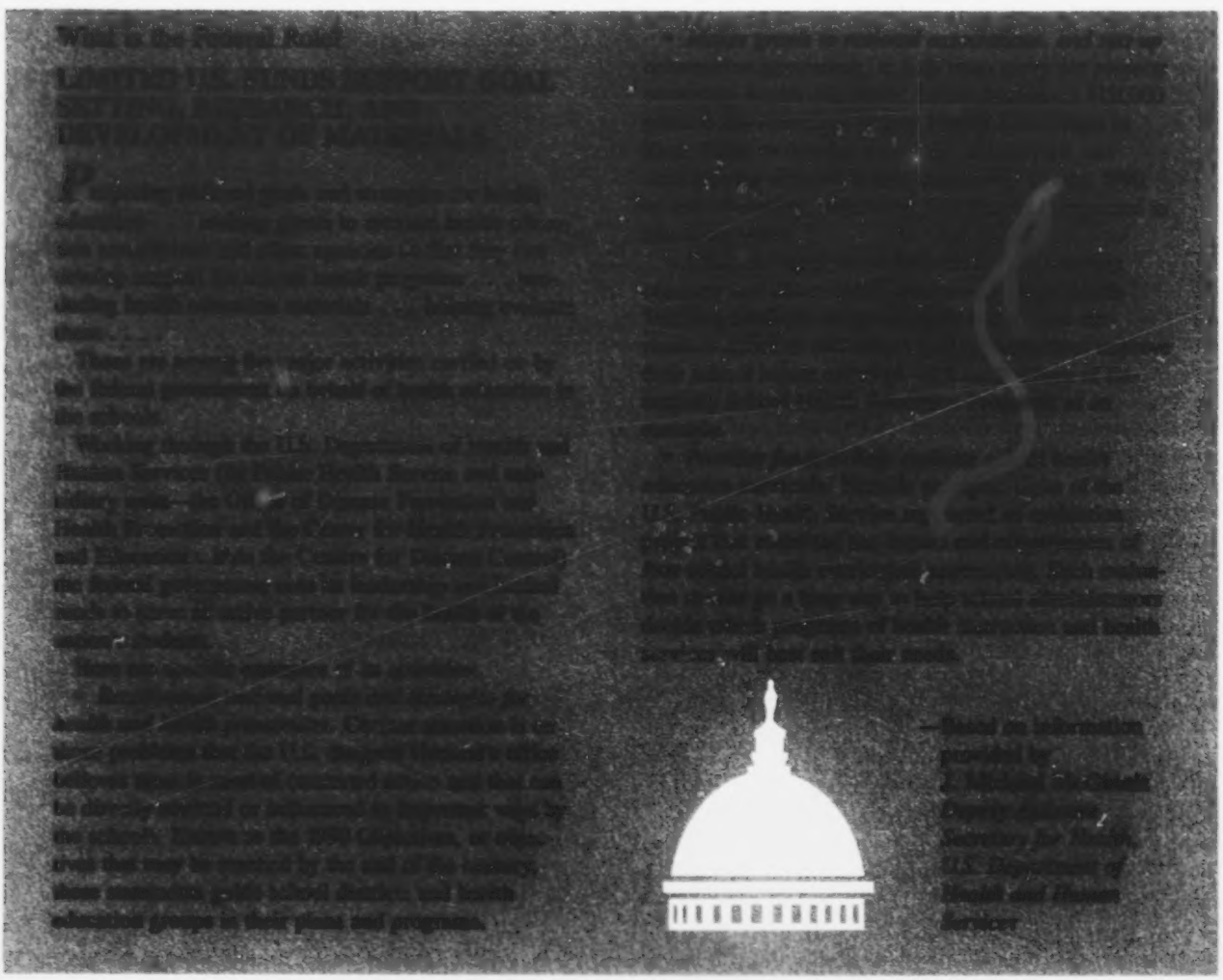
• Safe and orderly bus operation, with schedules attuned to needs of students, is another factor in a healthful school environment.

And there are more: school lunch and milk programs that meet nutritional standards. . .policies on smoking. . .adequate and safe physical education and recreation facilities. . .and, overarching all these, there is, as one superintendent put it, something that "hangs in the air." It is what superintendents have called "that friendly feeling," "high morale level," and "emotional tone."

In fact, the emotional tone that prevails among administrators, teachers, and students can reinforce classroom lessons in good interpersonal relations and stress management, or they can contradict what health teachers are trying to impress on students. "You don't get healthy students by setting aside 30 minutes every other day while a teacher tells a class what it's like to be healthy," says Pruitt. "You change behavior by establishing an environment in which certain types of behavior flourish and other types are discouraged."

The examples that school staff provide make a difference in whether health education takes effect among students. Role-modeling is important. Nancy H. Stevens found that, in Oregon, the two factors that best predicted whether a school would have a good health education program were: (1) the presence of a health promotion program for faculty and staff, and (2) the health behavior of the principal—whether he or she smoked or exercised, for example.

The importance of role-modeling has led some districts to push in the direction of wellness programs for school staff that give employees incentives and also the means to take care of their health. A program might encourage staff to stop



smoking or to take up physical fitness, dieting, nutrition, or stress management, for example. These types of programs try to get teachers excited about their own health. "As a result," says Nancy Stevens, who studied wellness programs in Oregon districts, in a paper co-authored by Lorraine G. Davis, "health has become more important in the classroom. They [the teachers] see the ability to integrate it into everything." Another effect, advocates say, is that the emphasis on health adds up to savings on health insurance and teachers' sick leave. "A healthy faculty is an inexpensive faculty," says Pruitt.

How Healthy Are Today's Children?

Aren't most school-age children healthy? They may seem to be, experts say, but in reality even young children may suffer from a surprising assortment of health-related problems. Some, like vision and hearing problems, are often caught by school screening programs. But other conditions may slip by. Some children in this country still come to school hungry. Many more are victims of poor nutrition. They eat too much of the wrong things—foods full of sugar, fat, and salt but short on nutritive value. Children with poor eating habits will probably lack energy. Worse, they may become obese, a definite risk factor for many serious diseases. When researchers for the National Children and Youth Fitness Study attempted to find out how physically fit American youngsters are, one of the things they measured was body fatness. They found that American children, on the average, in grades five through twelve, had grown fatter since the 1960s.

Accidents kill more children than diseases, and many accidents occur at school. But many children are hurt in auto crashes, and if the youngsters practiced seatbelt safety, the death toll would almost certainly be lower. More adolescents die in auto accidents where drunk driving is a factor than from any other cause. Venereal disease is also largely a problem of youth, with most cases concentrated in the 15–24 age group. A quarter of all girls in this country will be pregnant before their 19th birthday. Social pressures and emotional development changes also make the teenage years a difficult time for many youngsters.

Emotional stress can trouble even very young children. Says an article in the October 1984 issue of the National Association of Elementary School Principals' *Streamlined Seminar:* "Unrecognized and unchecked, [stress] can lead to serious consequences, including depression, aggressive behavior, and suicide."

Most children will not feel the impact of major health problems until later, when high blood pressure, high cholesterol, obesity, smoking, and low levels of physical activity will take a toll in terms of cardiovascular disease or cancer. As many as 36 to 60 percent of the children in this country exhibit at least one of the prime risk factors for cardiovascular disease—they smoke, have high blood pressure, are overweight, or have high cholesterol.

Is There a Relation between Health and Achievement?

A good health-promotion program helps children feel better and helps them learn more. "The healthy child learns best," is a slogan tacked over the desk of many health educators in offices across the country.

Experts agree. Those who have looked into children's health problems are convinced that health conditions have an immediate effect on how well children learn, although they may not always be able to prove a direct connection in terms of test scores (see sidebar, "Health and Achievement").

One view of the relationship between health and learning runs as follows: Children need to be attentive to stay on

"THE SCHOOLS— APPROPRIATE AND EFFICIENT. . ."

Our nation's schools provide an appropriate and efficient vehicle through which our population of young people can be educated about risks to their health and well-being. The ultimate goal of health education is the development of an adult whose lifestyle reflects actions that tend to promote his/her own health, as well as that of the family and the community.

—J. Michael McGinnis
Deputy Assistant Secretary for Health U.S. Department of Health and Human Services

learning tasks. Attention takes energy, and students who are physically fit, well-nourished, and stress-free have more energy.

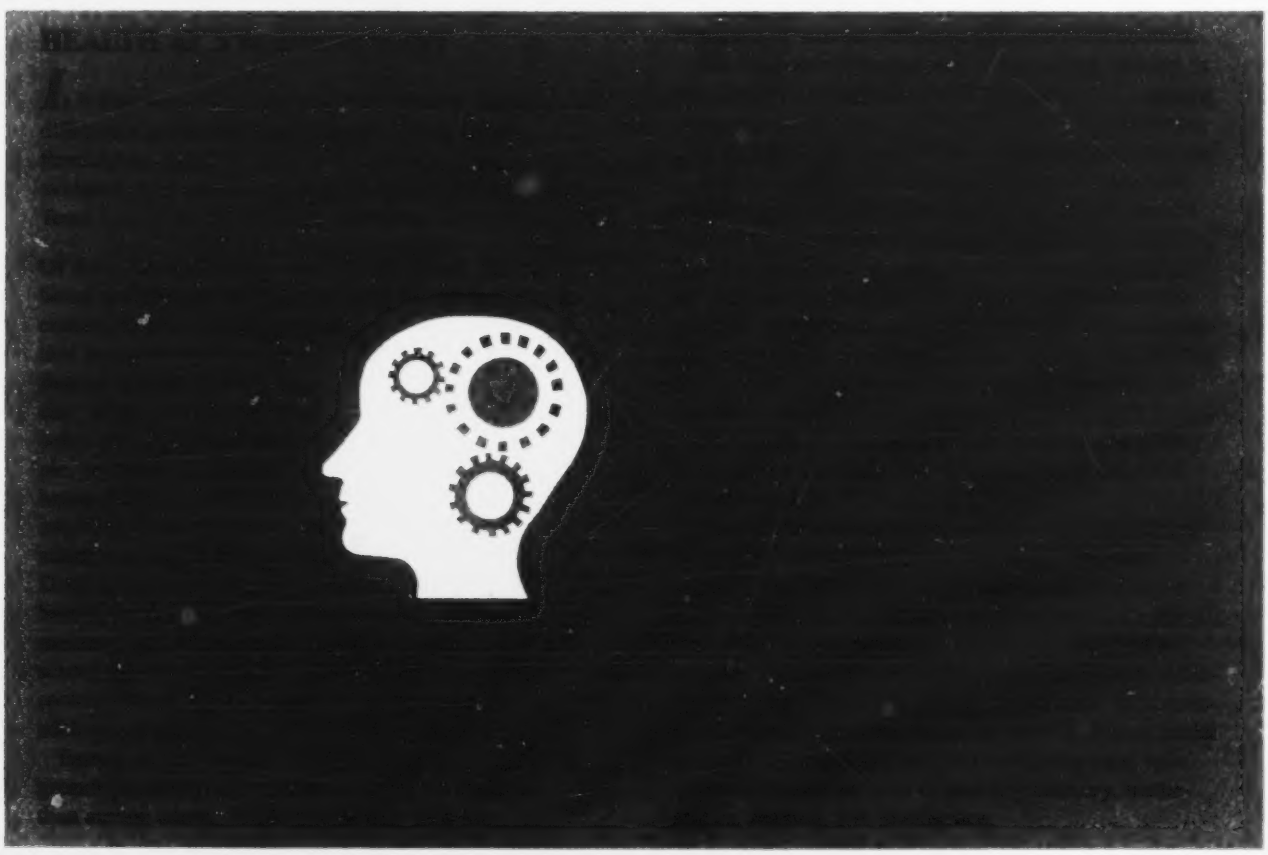
Why Are Good Programs Rare?

Comprehensive health education deserves a high position on a district's list of priorities. It can add to the quality of life for students and school staff, raise the level of health students can expect to enjoy as they grow older, and favorably influence learning itself. Nevertheless, relatively few districts have truly comprehensive health promotion programs. Estimates range from a low of about 4 percent to a high of about 15 percent of the nation's school districts.

Why is this so? One reason is that health education must compete for time and resources in an already crowded curriculum, especially at a time when some critics are urging schools to pay more attention to the basics and when financial resources are tight. Then, too, topics such as sex education are controversial in many districts. Wary administrators shy away from them—and may also stay clear of other aspects of health education under attack by conservatives and fundamentalists. Insufficiently trained teachers and a lack of good curricula also posed difficulties in the past. In many districts, health traditionally has been a low-priority item, a subject that coaches used to keep physical education students busy on rainy days. "Our greatest single problem is overcoming our own history," says one health educator.

Recent reports on excellence give mixed signals about the importance of health education. In *A Nation at Risk*, the National Commission on Excellence in Education implied that students spend too much time on health and physical education, time that would be better used in more rigorous academic courses.

Ernest Boyer, on the contrary, gave health education strong support in *High School: A Report on Secondary Education in America:* "Clearly, no knowledge is more crucial than knowledge about health. Without it, no other life goal can be successfully achieved."



The Push to Action

Whether to push for a strong health education program or not is up to an individual district administrator far more so than in other subject areas. While education codes in some 43 states refer to health education (without going much further), and 39 require it in some form, most states do not define either the scope of the subject or the amount of time that should be devoted to it. State enforcement of the health education requirements may be lax. It is not uncommon to find greater commitment at the local level than at the state level, observers have noted.

On the other hand, curriculum development in health education has taken a spurt in state agencies. Materials are now available from state capitols to help guide local curriculum developers. Several states have put together excellent curriculum guides that define scope and sequence for the subject at all grade levels and offer valuable teaching ideas.

The push to action, may, in the final analysis, come from the high cost of health care. The case for better school programs may come from a realization that it's cheaper to prevent illnesses than to treat them. "Maybe astronomically expensive treatment will make people realize that maladies can be prevented," speculates George S. Shackelford, chief consultant in health education with North Carolina's Department of Public Instruction.

Chapter 2

Needs/Goals

National needs and national goals in health—Listing the objectives of 12 health topics—Hazards and risks to the nation and to students—How schools join in the great national prevention effort

Declaring that "prevention is an idea whose time has come," the U.S. surgeon general in 1979 called for a new national health strategy, one that would emphasize prevention. In this strategy, the schools play an important role. The surgeon general envisions school health education programs that concentrate on topics where prevention has the biggest payoff.

The U.S. surgeon general's call came in the now-famous document, *Healthy People*, dealing with health promotion and disease prevention. In this report, he pointed to those health topics that, because they lend themselves to preventive strategies, deserve to be high priorities for education. Among them are high blood pressure control; immunization; sexually transmitted diseases; accident prevention; dental health; smoking; alcohol and drug abuse; food and nutrition; physical fitness; pregnancy and infant health; control of stress and violent behavior; and toxic agent control.

A similar call for preventive efforts comes from a second U.S. Public Health Service publication, *Promoting Health/Preventing Disease: Objectives for the Nation* (1980). This document spelled out scores of objectives for a far-reaching health and educational campaign. Most of the objectives are stated quite specifically—fewer deaths or cases of disease—to be reached by 1990, or at the latest, the end of the century. About 30 percent of the objectives pertain to what the schools can do, either alone or in conjunction with other institutions. "Twelve of them can't be accomplished anyplace but at school," says one school health authority.

U.S. public health service spokesmen emphasize that these objectives in no way suggest guidelines for a national health education curriculum. Rather, school officials are urged to look to local needs and sensitivities for indications about which topics should be included in their priorities. A review of the national objectives can, however, give district administrators an idea of the scope that a comprehensive prevention-oriented health education program might have.

The objectives presented in this chapter were chosen as most pertinent for the schools by health education researchers. Selection is based on one analysis by Lloyd J. Kolbe and Donald C. Iverson, and another by Nancy H. Stevens and Lorraine G. Davis.

FOR DISEASE PREVENTION FOR HEALTH PROMOTION

1. High Blood Pressure

Objectives for high blood pressure control, by the end of the century, are:

- At least 50 percent of adults should be able to state the principal risk factors for coronary heart disease and stroke (high blood pressure, cigarette smoking, high blood cholesterol, diabetes)
- At least 90 percent of adults should be able to state whether their current blood pressure is normal
- At least 60 percent of the estimated population with high blood pressure should have successful long-term control over the problem

Hazard and Risk:

High blood pressure is a "silent disease"; it usually does not produce symptoms that would warn victims to seek help before their lives are threatened. Yet, it is one of the risk factors for heart disease—the leading cause of death in the United States—and is the most important cause of strokes. It is twice as likely to affect blacks as whites, and most often it occurs among people with lower incomes and lower educational levels. It cannot be cured, but it can be controlled by medication. Its precursors can be seen even in children.

What Schools Can Do:

School programs can help alleviate this problem by teaching students what causes this disease: that obesity adds to the risk; that salt and a fatty diet can exacerbate it; and that physical fitness, good nutrition, and stress control can reduce the danger. Schools also provide blood pressure screening as part of the health services program. A ninth-grade risk reduction program in Normal, Illinois, for example, screens students in grades 7–12 for weight and smoking risks and for hypertension. Clinics to help students stop smoking and lose weight provide services in conjunction with the screening. In Atlanta, Georgia, students analyze the school lunch menu as one facet of a program aimed at coronary health.

Many districts have drawn upon American Heart Association materials for instruction in high blood pressure control.

A Boise, Idaho, cardiovascular health education program uses some of these materials to teach ninth graders the right techniques for coronary-pulmonary resuscitation; and in Los Angeles, California, students at Huntington Park High School give blood pressure tests to the public at school events.

2. Immunization

By the end of the century:

- At least 95 percent of all children attending licensed day care facilities and K–12 should be fully immunized, and 95 percent of these children should have up-to-date official immunization records kept in a uniform format
- Cases of measles, mumps, rubella, diphtheria, whooping cough, and tetanus should drop markedly, while polio should almost disappear

It's Preventable:

Each of the major childhood infectious diseases can be prevented by immunization. Consequently, the number of cases occurring annually has been greatly reduced in recent years. Nonetheless, children who are not fully immunized still suffer from these diseases and their sometimes-severe complications. Unfortunately, the very success of the vaccines for diseases such as polio and measles has instilled a sense of public complacency. For most of these diseases, this complacency is premature; so far, only smallpox can be considered eradicated worldwide. During a recent winter, a measles epidemic nearly closed down a major American university.

What Schools Can Do:

School immunization programs have been a valuable aid in the fight against these childhood diseases. But younger children, especially disadvantaged preschoolers, often don't have all the shots they need. Schools can help by stressing the importance of immunization in health classes and by getting the word to parents, who may have under-immunized preschool children. They can also help by keeping each school age child's record up-to-date, reviewing the record periodically, and reminding parents of required followups.

3. Sexually Transmitted Diseases

By the end of the century:

- Every junior and senior high school student in the United States should receive accurate, timely education about sexually transmitted diseases so as to decrease cases of chlamydia, gonorrhea, gonococcal pelvic inflammatory disease, primary and secondary syphilis, and other diseases of this type

Hazard and Risk:

Sexually transmitted diseases take a tragic toll among the young. The greatest risk is for youths between the ages of 15 and 24, who account for about 75 percent of all cases. Because the symptoms of these diseases are not readily apparent to victims, many do not recognize the seriousness of their problem while it is in the early stages, before permanent harm may be done to their bodies. Each year about 75,000 young women lose the ability to bear children because of complications of sexually transmitted diseases.

What Schools Can Do:

Young people need to understand early symptoms and the types of sexual behavior that increase risks. This kind of information is being taught in many health education programs. It should be available at all schools and taught before students are old enough to be at risk.

4. Accident Prevention

By the end of the century:

- Most parents of children under age ten should be aware of appropriate measures to address the three major injury risks to their children—motor vehicle accidents, drownings, and burns
- Motor vehicle fatality rates should drop substantially for all, and the rate for children under age 15 should be no greater than 5.5 per 100,000 children
- The home accident fatality rate for children under age 15 should be no greater than 5.0 per 100,000 children

Hazard and Risk:

Accidents pose the greatest single health threat to children and account for 45 percent of childhood deaths. Motor vehicle accidents cause 20 percent of these deaths; drownings, 8 percent; and fires, 6 percent. Poison still takes the lives of some children, although the proportion of these deaths grows smaller each year.

What Schools Can Do:

To help change these statistics, experts urge that safety education be integrated into school curricula at all grade

levels. Highway safety education (stressing the importance of seatbelts), water safety and swimming education and instruction about both the dangers and the proper treatment of burns and poisons should be part of safety education. A Providence, Rhode Island, program, for example, starts teaching kindergarten children about safety, and between kindergarten and grade 3 the program covers pedestrian safety, safety in the home, fire safety, poison prevention, and summer safety. A safety specialist covers each topic during the school year, with resource teachers offering followup lessons.

Programs teaching students to protect their eyes, ears, and teeth are common among school districts. A New York City program called "An Option to See" encourages students in grades 7–12 to use glasses to protect their eyes when they are engaged in sports, industrial arts, and vocational education activities. Another safety education priority in many districts is the link between car crashes and alcohol. Districts also teach children how to administer basic first aid, and some reach out to parents as well, making sure they have information about how to reduce the risk of accidents at home and know how to deal with emergencies.

5. Dental Health

By the end of the century:

- Nearly all school children and their parents should be aware of the principal risk factors related to dental diseases and understand how fluoridation and other measures help control them
- Most adults should be aware of the necessity for thorough personal oral hygiene and regular professional dental care to stop gum disease. A majority of the nation's school children should be proficient in their own oral hygiene and should be receiving other needed dental services
- At least 50 percent of school children living in fluoride-deficient areas that do not have community water systems should be served by a fluoridated school water supply
- No public elementary or secondary school should offer cavity-causing foods in vending machines
- Virtually all secondary school students who participate in organized contact sports should wear proper mouth guards

Hazard and Risk:

"Dental diseases probably constitute, in the aggregate, the most prevalent health problem in the nation," according to *Promoting Health/Preventing Disease*. These diseases are diseases of childhood, when cavities and gum problems begin. The most effective measure against cavities is fluoridation, especially fluoridation of community water supplies, U.S. public health officials say.

What Schools Can Do:

Children should be instructed about the link between sugary foods and tooth decay, instructed in proper dental hygiene—not just brushing, but flossing, too—and encouraged to get regular dental checkups. According to *Promoting Health/Preventing Disease*, 47 percent of the children in this country under 12 years old have never been to a dentist.

Sometimes, local dentists or dental schools help the schools instill these lessons. As part of a program at New York City's Public School 155, teachers arrange for kindergarteners to visit New York Technical College, where children (with parental permission) have their teeth cleaned. In Fairbanks, Alaska, dental consultants train teachers and visit elementary school classrooms to demonstrate oral hygiene techniques.

6. Smoking

By the end of the century:

- Most of those leaving the nation's schools should have learned that smoking is a major risk for heart disease, for lung and other types of cancer, and for chronic obstructive lung diseases, including bronchitis and emphysema
- Most women should be aware of the health risks if they smoke, including the effect on outcomes of pregnancy and the increased risk of cardiovascular disease for smokers taking oral contraceptives
- A majority of the nation's 12-year-olds should be able to identify smoking cigarettes with increased risk of serious heart and lung diseases
- The proportion of adults who smoke, especially women who smoke during pregnancy, should be under 25 percent, and the proportion of children and youth aged 12 to 18 who smoke should be reduced to less than 6 percent

Hazard and Risk:

Despite the best efforts of U.S. health agencies to publicize the frightening connection between smoking and debilitating or fatal diseases, about 4,000 children and adolescents start smoking every day and about one-third of all 18-year-olds smoke.

What Schools Can Do:

One of the biggest problems with students is peer pressure.

Youths who smoke tend to have friends who smoke, and they spread the habit to one another. To counter this tendency good school programs should explain how smoking harms the body, encourage a sense of self-responsibility for health, and teach students to resist peer pressure. Some districts also sponsor smoking-cessation clinics for students and, sometimes, for staff as well. And of course, many school districts restrict smoking on school property.

7. Alcohol and Drug Abuse

By the end of the century:

- Nearly all teenage girls should be aware of risks associated with pregnancy and drinking. Most adults should know there is an added risk of head and neck cancers for people who consume alcohol excessively, and most high school seniors should perceive great risk associated with marijuana use, barbiturate use, and alcohol intoxication

Hazard and Risk:

Alcohol and drug abuse are not only long term health hazards, but they pose an immediate threat to school-age youths. Motor vehicle crashes take the greatest number of lives in the 15–24 age group, accounting for 37 percent of all deaths, and alcohol has something to do with a great many of these crashes. Substance abuse increases the danger of homicide and suicide, disrupts families, and leads to poor school work. It is also a threat to young pregnant women, whose babies may be born with defects as a result.

What Schools Can Do:

Educational strategies to help students avoid these pitfalls often resemble those used in smoking education programs. They hit on the theme of individual responsibility, teach how to cope with peer pressure, and demonstrate how the use of dangerous substances damages the body.

In districts with comprehensive health education curricula, the warnings are repeated as students move through the various grades. A Seattle, Washington, program, "Here's Looking at You Two," fosters positive self-concepts and coping skills from kindergarten through high school. Some programs for older students make use of peer educators or peer counseling groups. Other alcohol abuse programs concentrate on exposing the link between drunk driving and traffic accidents. Educators in Lincoln, Nebraska, for example, offer a ten-class-period curriculum that helps teach ninth graders how to resist peer pressure either to drink and drive or pressure to ride with drivers who've been drinking.

8. Food and Nutrition

By the end of century:

- Upon leaving high school, most of the nation's youth should know the principal dietary factors related to heart disease, high blood pressure, dental cavities, and cancer; should be able to identify foods that are low in fat and sodium content and high in calories or fiber; and should realize that to lose weight, they must either eat foods with fewer calories, increase physical activity, or both
- All states should include nutrition education as part of required comprehensive school health education at elementary and secondary levels

Hazard and Risk:

Nutritional problems are more than likely the result of poor food choices—eating too much; eating foods with too much sugar, fat, or salt; neglecting fresh vegetables or whole-grain cereals. Consequently, school health education programs usually concentrate on giving children the knowledge and skills they need to choose food with nutritional value. Sometimes, students are surprised at how many empty calories their diets contain; school officials at Minot High School in North Dakota report that this often happens when students keep weekly records of what they eat and then do computer analyses of the calories and nutrients in the food.

Health educators see a direct link between diet and diseases, and one of their major targets is obesity. No longer seen as a problem that hurts only appearance, this condition is treated as a health threat. Mounting evidence indicates that obesity can be a killer: A National Institutes of Health panel warned in 1985 that obesity represents as great a threat to health as smoking. Many obese adults started out as obese children.

What Schools Can Do:

Some school programs go beyond teaching about the dangers of obesity. A middle school weight-reduction program in Manatee County, Florida, weighs students on a weekly basis and encourages them to form mutual support groups so that dieters won't give up. School food service managers there color-code lunch menus to indicate low-calorie lunches, and students can arrange also for salad lunches.

9. Physical Fitness

By the end of the century:

- Most adults should be able to identify the types and duration of exercise that best promote cardiovascular fitness
- Ninety percent of all school-age children and adolescents should be participating regularly in appropriate physical activities, particularly cardiorespiratory fitness programs that can be carried into adulthood; and 60 percent of the adolescents should participate in daily school physical education programs throughout their high school years
- A method for systematically testing the physical fitness of children should be established, and at least 70 percent of children and adolescents ages 10–17 should have access to this type of evaluation

Need for Fitness:

Physical fitness depends on exercise that helps shape up a student's heart efficiency and increases the amount of oxygen that the body can process in a given amount of time. For individuals who do this kind of exercise on a regular basis, medical authorities say, the risk of developing cardiovascular disease may be half as much as it is for those who do not. Health educators also point out how fitness, nutrition, and stress reduction together can make a difference in a person's overall sense of well-being.

The U.S. Public Health Service defines appropriate physical activity for fitness this way: exercise that involves large muscle groups in dynamic movement for periods of 20 minutes or longer, that does this three or more times a week, and that is performed at an intensity requiring 60 percent or more of an individual's cardiorespiratory capacity.

How close do American schools come to meeting the fitness objectives suggested for 1990 or the end of the century? When the national fitness study looked at school physical education programs, investigators found that only 36.3 percent of the students in grades 5–12 had physical education every day. Over 80 percent of the students in those grades were enrolled in physical education sessions meeting an average of 3.6 times a week, however. Student enrollments peaked at 97 percent in grades 5 and 6, and then dropped off to less than 50 percent in grades 11 and 12.

What Schools Can Do:

The study also concluded that school physical education programs were not providing enough opportunities for students to learn lifetime sports—a major goal of physical fitness advocates. Instead, too many programs were limited to competitive and team sports, which many students cannot pursue once they leave school. Some schools are setting up "lifetime" sports programs by including aerobics, running, and other such activities in their physical education programs. As for the intensity of exercise in physical education classes, the study found that only about half the children in grades 5–12 were engaging in "appropriate [vigorous] physical activity" for the minimum time the objectives would require. And although 97 percent of the fifth and sixth graders were taking physical education at least weekly, the students had too little opportunity for what the study calls "effective participation." For 54.6 percent of these children, physical education consisted of only one and one-half hours each week, and much of that time was spent on relays and informal games, rather than on lifetime sports.

10. Pregnancy and Infant Health

By the end of the century, most women of childbearing age should be able to choose foods wisely, aware of what foods meet the special nutritional needs of pregnancy, and should understand the hazards of smoking, alcohol, and other drugs during pregnancy and lactation.

Hazard and Risk:

Nearly two-thirds of the infants who die in this country are low birth-weight babies, and the mothers most likely to have those babies either had too little prenatal care or were very young themselves. The problem is far more likely to affect blacks than whites.

What Schools Can Do:

Parenthood education, nutrition education, and programs that explain how alcohol, smoking, and drugs can harm an unborn child are helping correct this problem in some parts of the country. Some school programs provide counseling for teenagers, especially those who are already pregnant. One such program is a March of Dimes-sponsored curriculum, *Healthy Mothers, Healthy Babies*, that helps teachers at all grade levels provide instruction about the nutritional needs of pregnant women.

11. Control of Stress and Violent Behavior

By the end of the century:

- Over 50 percent of the high school students over age 15 should be able to identify a community agency that can help them cope with a stressful situation

ANOTHER PROBLEM —ANOTHER GOAL?

Federal public health officials draw attention to still another national problem: children are having children—at a time when they are unprepared to cope with the consequences.

Child bearing during adolescence is a high-risk experience for mother and child alike. Nevertheless, one-fourth of America's teenage girls have had at least one pregnancy by age 18, and more than 25 percent of these girls are pregnant again within the year after they deliver. These young mothers are frequently from low economic groups, and just as frequently their pregnancies are unplanned.

Public health officials in Washington want to encourage elementary and secondary schools to initiate and maintain family life curricula that deal with human sexuality, reproduction, contraception, and parenting. A one-semester program at University City Senior High School in Missouri, tries to increase what students understand about sexuality and, at the same time, give them the skills and ability to resolve conflicts—two assets for family relations. The course covers topics such as sexuality and health, sex roles, teenage relationships, human sexual response, family relationships, considerations about parenthood, contraceptives, decision making, pregnancy and birth, and sexually transmittable diseases.

Making it easier for pregnant teens to finish high school is a top priority for some programs, and evidence is growing that such efforts may help reduce repeat pregnancies. Results of a program at the Johns Hopkins Medical Institute in Baltimore, Maryland, indicate that 85 percent of the young mothers enrolled in the program went back to school, and of these only 5 percent were again pregnant within a year.

Federal public health officials maintain that the public schools do have a role in family planning. With the help of education, they stress, it will be possible to ensure that, by the end of the century, there will be virtually no unintended births to girls 14 or younger and that the fertility rates for 15-year-old girls will be sharply reduced. Similarly, educational programs should also reduce the fertility rates for girls in the 17- through 19-year group.

- The proportion of young people ages 15–24 who can identify an accessible suicide prevention "hotline" should be greater than 60 percent
- The death rate from homicide among black males ages 15–24 should be reduced to below 60 per 100,000
- The rate of suicide among people 15–24 should be below 11 per 100,000

Hazard and Risk:

Stress has a relationship to health and illness. It may play a part in both psychological and physical symptoms, such as obesity, absenteeism, headaches, and other illnesses. It may also manifest itself through violence, or even through suicide or homicide: suicide is the second highest cause of death for students—increases in the suicide rate are capturing national attention.

What Schools Can Do:

Although no school program can remove all the stress from students' lives, education can help them learn to cope with stressful events. Ideally, students should start learning to cope during their elementary years, and health educators often seek to instill self-esteem at that age. They may also teach students how to practice relaxation techniques and other coping strategies.

For older students, programs sometimes use a multifaceted approach. One Boston, Massachusetts, program for grades 8–11 called "Self Discovery" concentrates on practical skill-building strategies that increase self-acceptance and the ability to manage stress and strong feelings and to form healthy relationships. The program encourages students' families to participate. In Oregon, some school districts treat suicide prevention as one element of their stress management programs.

12. Toxic Agent Control

- By 1990, at least half of all people ages 15 and older should be able to identify the major categories of environmental threats to health and note some of the health consequences of those threats

Hazard and Risk:

The past few years have made it abundantly clear that many substances and materials in the environment pose serious

health threats. These substances can cause reproductive and developmental problems, cancer, chronic degenerative diseases, and neurological damage. "There is virtually no major chronic disease to which environmental factors do not contribute, directly or indirectly," states *Healthy People*.

As of 1979, the National Cancer Institute listed at least 20 chemicals as possible cancer-causing agents. More than 2,300 other specific chemicals are suspected carcinogens.

What Schools Can Do:

Health education programs should help students become aware of and recognize the toxic substances they may encounter in the home, school, and neighborhood environment and, in later years, on the job. School administrators should be sure that school buildings and grounds do not contain exposed hazardous substances, including asbestos.

TOOLS TO START WITH. . . .

When a school health committee, faculty group, or districtwide school health committee sits down to plan, revise, enhance, modernize. . . .

. . . .the materials listed below should be on the table, or ready for easy reference.

The documents are startup tools. They will provide basic data, suggest policy lines, offer options for the acquisition of programs available for purchase.

- *Healthy People: The Surgeon General's Report on Health Promotion and Disease Prevention*, 1979, available from the Government Printing Office, Superintendent of Documents, Washington, D.C. 20402, $6.
- *Promoting Health/Preventing Disease: Objectives for the Nation*, 1980. Available from the Government Printing Office, Washington, D.C. 20402, $5.
- *Prospects for a Healthier America: Achieving the Nation's Health Promotion Objectives*, 1985. This is a followup of the two documents cited above. A limited number of copies available from National Health Information Clearinghouse, P.O. Box 1133, Washington, D.C. 20013.
- *Common Questions and Answers Regarding School Health Education Program Development and Improvement*, 1984. National Health Information Clearinghouse, P.O. Box 1133, Washington, D.C. 20013.
- *Standards of School Nursing Practice*, American Nurses' Association, 2420 Pershing Road, Kansas City, MO 64108.
- *State Policy Support for School Health Education: A Review and Analysis* (Report No. 182-1), Education Commission of the States, available from Education Services, American Council of Life Insurance, Health Insurance Association of America, 1850 K St. NW, Washington, D.C. 20006.
- *School Health—A Healthy Child: The Key to the Basics*. A marketing kit for school planning groups, containing leaflets, lists of publications on health topics, and including "Why Health Education in Your School?" American School Health Association, P.O. Box 708, Kent, OH 44240.
- *School Health—A Guide for Health Professionals*. Available from the American Academy of Pediatrics, 141 Northwest Point Blvd., Elk Grove Village, IL 60007.
- *A Compendium of Exemplary School Health Education Classroom Programs and Teaching/Learning Resources*. Revised, 1984. This document describes more than 120 local, state, and national programs, giving information about target audience by grade level, goals, materials required, evaluation results, and names and addresses of persons who will provide additional information. Inquiries about this resource should be directed to Roy L. Davis, Center for Health Promotion and Education, Public Health Service, 1600 Clifton Road, NE, Atlanta, GA 30333.
- Copies of *Health Education*, a journal published by the Association for Advancement of Health Education, 100 Association Drive, Reston, VA 22091.

Also on the table, or available for easy reference, should be:

- Your district's board policies on health education
- Superintendent's regulations
- State laws pertaining to school health
- Your district's curriculum guides on health
- Your state agency curriculum guides and materials on health.

Chapter 3

Local Needs/Local Goals

How school districts derive objectives for health promotion—Sources of local goals: national needs, community needs, student needs—Goals for curriculum and goals for administration

Anyone setting out to revise, change, or enhance the school health program will find plenty of ready-made goals and objectives.

They may be printed in textbooks, in the district's old health curriculum guides, or in materials available from neighboring school systems.

They won't do.

A modernized health program will come about only as district educators re-examine the traditional goals, reassess their worth for the present and the future, and then proceed to develop goals that are right for the community, family, and the student—for now and the years ahead.

What are the sources and inspiration for such goals?

One way to find them is to study the health needs and condition of the students; to explore the health needs and conditions of the community; and to search out the advice of specialists in medicine and health.

It is a good approach; and it is likely that one or more of the district staff, at one time or another, in one way or another—even without systematic plans—have been or are engaged in some aspects of this approach.

Nine Sources: The systematic search for new health goals, however, leads to a use of these sources and instruments:

- From the national government there are the indispensable and challenging goals formulated by the U.S. Surgeon General and federal public health agencies, as outlined in Chapter 2.
- From your state, there are legal requirements on health instruction and, probably more helpful, the informational and advisory documents on health prepared by the state education agency.

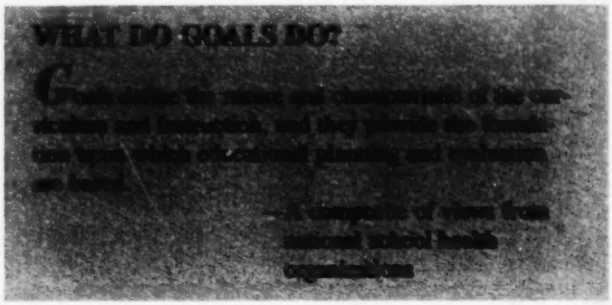
From the local levels:

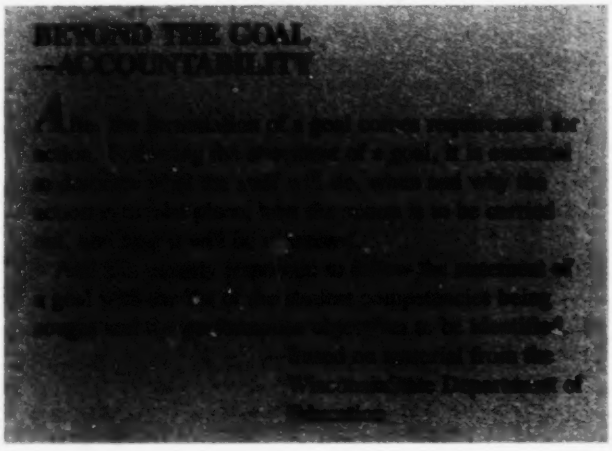
- Samplings of public opinion (from polls, hearings at board of education meetings)
- Needs assessment studies
- Community advisory committee recommendations
- Board policy statements
- Faculty and administration recommendations
- School health committee proposals
- Data on student health needs and conditions.

Nature of a Health Goal: Those who are developing lists of health goals, says the Wisconsin State Department of Education, should keep in mind these characteristics of an effective goal:

- It should reflect local philosophy, need, and ability to deliver
- It should set forth realistic program expectations
- It should be consistent with state goals and national goals.

Sensitivity to actual health needs is an overarching trait of effective health goals. From the AASA survey for this report come these points:



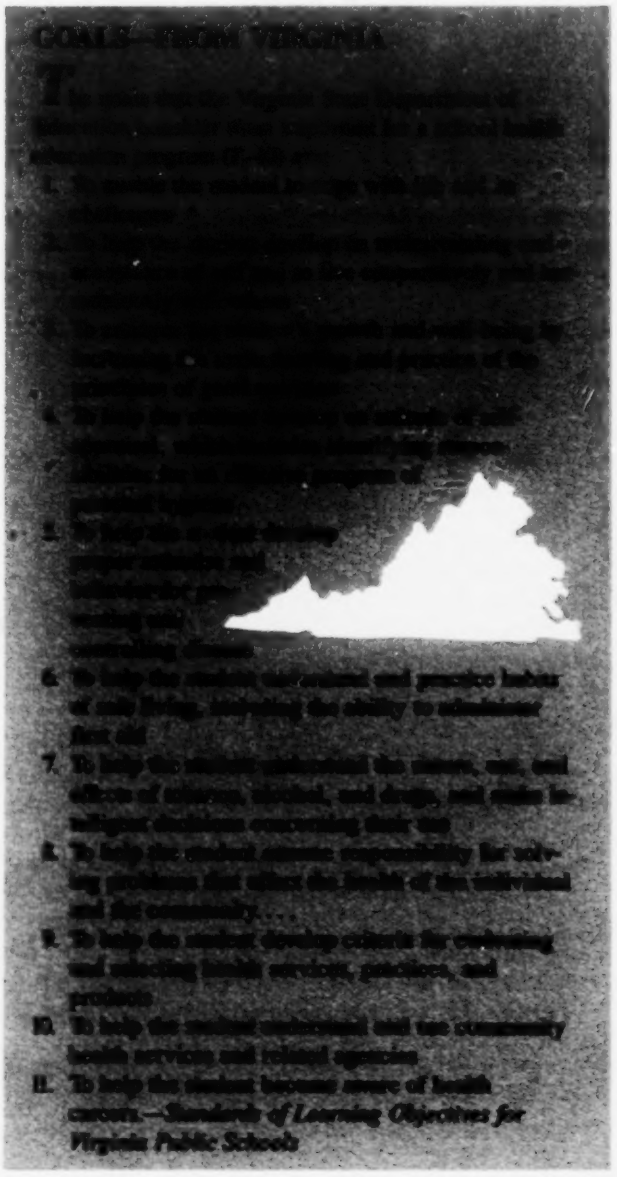


. . .In a community where drunk driving has taken young lives, accident prevention and substance abuse should rank high among health goals. . . .In a district where pollution is more than an ordinary hazard, a portion of the health curriculum should focus heavily on environmental risks. . . .Or, as an example, in the Colorado mountains, where exposure to cold poses a danger, teaching about that topic would be a priority goal. . . .

Goals for Administration

As curricular and instructional personnel seek to develop educational goals, administrators have a responsibility to support their work with goals requiring executive action. Here are administrative goals frequently reported by superintendents as they seek to support health promotion. How would you rank these in terms of priority for your district?

Administrative Goal	Your Priority Rank
Update school board policies	_____
Increase budgetary allocation for health	_____
Increase efforts for inservice	_____
Set up office of health coordinator	_____
Improve operations of health coordinator	_____
Revise selected curriculum guides on health	_____
Plan new efforts to obtain community help/ resources	_____
Acquire new types of instructional materials	_____
Devote entire board meeting to health	_____
Implement staff wellness plan	_____
Others: _____	_____
_____	_____
_____	_____


GOALS—FROM VIRGINIA
11. To help the student become aware of health careers.—Standards of Learning Objectives for Virginia Public Schools

Chapter 4

Management

Get your board policies and regulations in order—First tasks of leadership in health promotion—Health coordinators, school health and community advisory committees—Time for instruction and money to pay for it—Managing for a healthful school environment

A modern school health promotion program starts with modernized written school board policies.

If your district hasn't reviewed and, if need be, revised, its policies on health and its related areas within the last three years, action is overdue.

Note the emphasis on the plural—*policies* and related *areas*. While the major statement on what the school board expects and wants from a health education program can be brief, and philosophical, such a statement must be supplemented by policy statements on more than a dozen topics. The National School Boards Association coding system suggests the following list:

- Advisory committee on health education
- Budget planning for health
- Safety program
- Building and grounds inspection
- Accident prevention
- Food services
- Staff health and safety
- Smoking on school premises by staff
- Health education
- Teaching about drugs, alcohol, tobacco
- Family life education
- Sex education
- Physical examination of students
- Immunization of students
- Student safety
- Relations with health authorities

How Policies Develop

The topic list is neither inclusive nor prescriptive. Each board and each administrator must decide how adequate their policy manual is; and how adequate their policies on health are for their communities.

To review existing policies for adequacy is not too difficult. Revising or adding new ones is another matter.

"School board policies aren't written; they are developed over long periods of time," says the National School Boards Association. Its consultants on policy revision add that it often takes more than a year to update a district's policy manual; and it may require months for a school board to reach agreement on such controversial policies as sex education, family planning, teaching about drugs and alcohol.

Board policies on health will be sound only as teachers, principals, and curriculum directors contribute to their content; and only as both the medical community and the general community have their chance to propose ideas, suggest revisions, and express their views.

The Education Commission of the States recommends that board policies encourage community and parental involvement, define program goals and objectives, and contain a plan for developing and implementing programs. Board policies may also approve topics to be covered in the health curriculum and mandate how controversial areas should be handled.

The Many Uses of Policies

One great utility of school board policies on health promotion is that they form a line of defense for the board, administrators, and teachers. For if complaints, protests, and even lawsuits develop, the school system can fall back on the fact that health education is being carried on in accordance

with well-explored policy, to which many voices and many hands had contributed.

Several good things can follow as a result of the policy development process. Administrators can get behind a health education program with confidence, and they can prepare a health budget adequate to meet the district's needs and board expectations. Both the school board and the public will be more likely to understand and to endorse health education efforts. Teachers and other staff members are also more likely to be encouraged and inspired to work with new zeal for health. One point to remember is that a high-quality health education program often owes its existence to the dedication and enthusiasm of a single individual—an administrator, a curriculum worker, a teacher; or to a small group of staff members who begin a crusade for better health education knowing that the school board is behind them.

Number One Ingredient

But the superintendent's leadership is a prime necessity, and a first action for the superintendent is to take a fresh look at the work of the districtwide health coordinator.

Selecting the Health Coordinator: Picking and keeping the right person for this slot is crucial. Coordinators must be able to convey the importance of health, by word and deed, to the staff, parents, and community groups. They should be enthusiastic supporters of health promotion. Some authorities think that enthusiasm is more important than educational background or experience. Coordinators should practice good health habits themselves. Consequently, as superintendents look over candidates for the post, they might wish to consider questions such as these: Does the candidate smoke? Is he/she noticeably overweight? Active and physically fit? Able to work with others without generating stress? For more discussion of the health coordinator roles, see Chapter 6.

What Coordinators Do: Health coordinators should be politically savvy. They must know where to find influential individuals and organizations in the community and gain their cooperation, and they must foresee stumbling blocks that some local groups might try to throw in the way of the newer facets of health promotion. At the same time, coordinators must have enough clout to keep control of the program in the hands of school officials. "The last thing that schools would want would be to have a community group tell them what to do in the classroom," says Robert Gold. "While it's true that physicians think they understand what health education is and can contribute to a program, you can't allow the program to revolve around them."

Allies for Health

Administrators are sometimes surprised at the many potential health-minded allies they have in the community. "Administrators often don't realize the extent of the support—materials and money—that they can get from the local health community," says Kathleen Middleton, National Center for Health Education, at Concord, California. "Community groups can provide political support, materials, and guest speakers for programs," she continues. "They need to be involved."

Mobilizing people is part of the health coordinator's job. They must keep in touch with local physicians, nurses, representatives of voluntary health agencies—the American Cancer Society, the lung and heart associations, dental organizations, and public health groups. In West Bend, Wisconsin, health coordinator R.E. Held discovered that the local mental health center was an invaluable source of support. "The center is very active," he explains, "and this is a mental-health-conscious community." Mental health specialists, along with local doctors, nurses, and sheriff's office representatives have worked with the schools in West Bend.

Forming Advisory Committees

Many districts have organized community advisory groups for health promotion. In doing so, it is important that all types of community representatives have a chance to help shape a school health program. Some health topics, especially sex education, are controversial in some localities. Community advisory groups composed of parents, ministers, and minority group members can help educators tap the community's feelings on sensitive issues. Such groups can make sure that factual, unbiased information about what the schools are trying to do is communicated to all community segments. Be sure to include representatives of groups likely to question the need for health education, experienced administrators urge. Endorsing this point, one national health education leader says: "Many groups are 'anti' because they don't know what they're talking about. An anti-sex-education person will often convert after he or she sees what a comprehensive health education program really contains."

Community advisory groups can help substantially by conducting surveys and probing community attitudes on health needs. Most authorities believe that a needs assessment should be made before programs begin, change or expand.

Sometimes surveys turn up results that administrators or boards of education don't expect. One door-to-door survey in an Oregon school district produced evidence that more than 80 percent of the residents were in favor of school sex education—to the surprise of school authorities. The school board, which had assumed that the community opposed this topic, changed its position as a result.

Two further points to keep in mind when organizing advisory committees: First, spell out roles and responsibilities well in advance so that committee members know how far their say about the program extends. Second, be sure that the medical people included on the committees are prevention-oriented.

The School Health Committee

"No school district should be without a school health committee," wrote one superintendent, "because no school health program can be effective without one." Provided, that is, he added, that the committee is made up of people representing the interests of teachers, administrators, parents, health service personnel, food service, and those concerned with safety.

The school health committee can take on a range of duties and responsibilities. Some sample duties/responsibilities carried on by school committees across the country include:

- Develop statements of philosophy for consideration by administration and school board
- Develop objectives for districtwide programs of health education, as well as for grade levels and school buildings
- Assess the needs for inservice education to prepare elementary and secondary teachers for expanded roles in health education
- Review the time allocated for health instruction at all grade levels and recommend changes as necessary
- Determine the need for new curriculum materials on health
- Determine and evaluate the opinions and attitudes of classroom teachers and suggest ways for meeting the needs of staff and faculty
- Work in close contact with health coordinators and lend the committee's assistance to their work
- Work with the communitywide advisory committee.

Allaying Fears and Concerns

The most sensitive health education topic is sex education. Drug and alcohol education, once somewhat controversial, no longer creates as much difficulty as before, the AASA survey shows.

Whatever the parental fear or concern—whether about sex education, drugs, or fluoride—health educators can allay them by being open with the public and the community. Allow parents to scrutinize instructional materials and leave up to parents the final choice about whether a child takes a specific course offering.

Liane Summerfield, assistant professor at Marymount College in Arlington, Virginia, and consultant in health education, took several steps to reassure parents as she developed a health education program for a parochial school attached to Marymount. "It's a good idea to hold a lot of meetings with parent organizations and teachers before a disputed topic comes up at the board of education. Do this from day one; don't just have a big shot in health education come in and tell them what should be done." Summerfield invites parents to come into the classrooms to see what their children are learning.

About Instructional Time

Finding time for instruction can be a major problem for administrators. The amount of time needed to teach children about health has been a debatable question until recently. States offered few if any guidelines.

Now, however, several states have set specific time requirements for health instruction. Oregon, West Virginia, Indiana, and Wisconsin require specific time allotments for health education for high school graduation. Other states have set elementary school requirements—Georgia now calls for 30 hours of health teaching each year in K–8; Louisiana requires 30 hours in grades nine and ten.

Wisconsin's time allocation for health is exemplary (see chart, *Time Allocation*.)

Educators in Westbend, Wisconsin, have been ready for these recommendations. The district already (spring 1985) reserves 30 minutes a week for elementary and junior high school health education at each grade level and requires a full credit in high school.

The Cleveland County, North Carolina, schools also devote a specific amount of time to health education. Elementary school teachers generally set aside 30–45 minutes per day for combined health/science lessons. At the junior high school level, health education per se is taught daily every other week, and high school students take health every day for one semester. In Van Buren, Arkansas, a district that adopted the School Health Curriculum Project—one of the most important large-scale health curriculum development efforts of recent years—teachers give middle elementary school students approximately 18 weeks of health, averaging from 35–45 minutes every day. Sixth and seventh graders have a semester of health, with a class period averaging about 55 minutes.

HOW MUCH TIME FOR HEALTH EDUCATION?

The chart on time allocation is the product of the Wisconsin State Superintendent's Task Force on Health Education. It is one of the most carefully worked out timetables for offering health periods and classes, K–12.

The recommended time allocation is "in minimum numbers of instructional periods."

TIME ALLOCATION

	Recommended Number of Periods Per Year One Year = 34 Weeks							Recommended Number of Periods Per Semester	
	K	1-2		3-4		5-6		7-8-9	10-11-12
	45 min. per wk. (1) period = 15 mon.	75 min. per wk. (1) period = 25 min.		100 min. per wk. (1) period = 25 min.		125 min. per wk. (1) period = 50 min		(1) course meeting, 90 periods in a semester. (1) period = 50 min.	(1) course meeting, 90 periods in a semester (1) period = 50 min.
	Grade Levels								
School Health Education Major Content Areas for Classroom Instruction	15 min. periods	25 min. periods				50 min. periods			
	K	1	2	3	4	5	6	7-8-9	10-11-12
I. Accident Prevention and Safety	15	12	12	15	15	6	5	5	14
II. Community Health	0	0	0	6	6	5	5	5	5
III. Consumer Health	0	0	0	6	6	5	5	10	8
IV. Environmental Health	0	0	0	6	6	5	5	10	10
V. Family Life Education	6	9	9	12	12	10	10	15	12
VI. Mental and Emotional Health	18	18	18	18	18	13	15	12	8
VII. Nutrition	18	18	18	18	18	10	10	5	5
VIII. Personal Health	18	18	18	18	18	13	12	10	9
IX. Prevention and Control of Disease	6	6	6	6	6	3	3	3	4
X. Substance Use and Abuse	6	9	9	15	15	15	15	10	10
Total Periods	87	90	90	120	120	85	85	85	85

*The recommended periods for a year *do not* necessarily mean that all instruction should be completed in that specific content area in consecutive lessons.

Note: A study sponsored by the U.S. Department of Health and Human Services shows that if 6 to 8 percent of classroom time goes to health (about 1.8 hours per week based on a six-hour school day), there will be measurable benefits for students' knowledge and attitudes about health and that there will be behavior changes as well.

School Environment: Management Challenge

From asbestos to graffiti . . . from smoke-filled faculty lounges to teachers gnawed by low morale—these are elements in a school system environment that require management action.

The most visible and intrusive school environmental problem in the 1980s is the presence of asbestos in many of the nation's schools.

Here is a status report (late 1985) on this condition:

Asbestos Removal: It's Still a Muddle

It has been more than a decade since the uproar over asbestos in school buildings began, but ground rules on the best way to deal with this hazard are still far from clear. Administrators must decide whether to remove the asbestos completely or to enclose it somehow, by encapsulating it with a spray or putting sheet rock or some other material over it. Both options have disadvantages. Removing asbestos costs between $4 and $12 a square foot, says the *Wall Street Journal* (March 26, 1985). An AASA survey of 2,600 school districts in 1984 found that the average cost per district in responding districts was $128,330 for asbestos removal and $22,703 for encapsulation. (The AASA report on the status of asbestos efforts, *Asbestos in Schools: Inspection and Abatement*, is available from the Office of Governmental Relations, AASA, 1801 N. Moore St., Arlington, Va. 22209.)

Unless the asbestos abatement is done right, attempts to remove the material can backfire. Asbestos fibers can be released into the air and can spread to areas not previously contaminated, something that happened recently in some New Jersey schools. Encapsulation doesn't always work, either, because in a few years the asbestos may start crumbling out again. Some New Jersey school administrators charge they were getting conflicting opinions on the best course for handling asbestos problems from both government officials and private consultants.

To make matters worse, health insurers are starting to balk at covering asbestos removal crews, fearing their workers will eventually develop asbestos-related diseases and run up mammoth medical bills. Consequently, some experienced crews are being sidelined, while firms with no insurance, and little experience, take their places.

Experts have two pieces of advice for school administrators, the *Wall Street Journal* reports: (1) Don't rush into things, and (2) be wary of taking a low bid, unless it comes from a company with insurance and proven expertise. The Environmental Protection Agency offers these guidelines for choosing a qualified firm:

- Insist on references
- Ask for evidence of training in removal work
- Insist on proof that company employees understand the dangers of exposure and know how to use respirators and take decontamination measures.

The EPA, in ranking the degree of danger presented by different types of asbestos, says that badly damaged, exposed asbestos presents the greatest threat. Crumbling asbestos in air spaces ranks second. Some authorities believe that schools with the less-dangerous kinds of asbestos exposure might consider delaying action until the advantages of various courses of action are less confused and until asbestos removal crews are not tied up at schools with the most serious problems. "If it's not exposed and it's not friable, just keep an eye on it," advises Edward Keller, of the National Association of Elementary School Principals. "If it becomes dangerous, then encapsulate or remove it." Schools with crumbling (friable) or airborne asbestos must act promptly.

Other Environmental Hazards

"Asbestos has received the most publicity," says Oris Blackwell, an environmentalist at Eastern Kentucky University, "but the problems are not limited to asbestos. Hazardous substances also may be found in art materials and in science laboratories—the dangers involve everything from injuries due to chemicals and equipment to diseases that can be transmitted to humans from rodents, insects, and other creatures." School administrators often fail to give adequate attention to sports and playground equipment that can cause injuries.

Blackwell's list of areas that deserve attention includes drinking water, sewage, plumbing, illumination, noise control, heating and cooling, injury control, pest control, food hygiene, and general cleanliness. "Dirty rest rooms are a problem we see over and over again, and the same can be said for a lot of physical education facilities and equipment," says Blackwell.

A task force of the American Public Health Association and the National Environmental Health Association is working on a manual that will contain a code for creating a healthful and safe school environment. For information on this project, contact Oris Blackwell, task force chairman, at Eastern Kentucky University, Richmond, Kentucky 40475.*

*Note: The Centers for Disease Control in Atlanta, Georgia, have published a booklet entitled *Health and Safety in the School Environment: A Manual of Recommended Practices*, that has been a help to school administrators (write CDC, 1600 Clifton Road NE, Atlanta, GA 30333).

What Administrators Do

The single most important thing that superintendents and principals can do for health promotion is to stand behind the program, letting teachers, students, and parents know that the administration thinks health education is important.

Principals should set examples for students and school staff by observing good health habits themselves—researchers in Oregon concluded that in that state, a principal's health behavior is "a most important" indicator of a quality health education program.

This does not mean that principals should be judged on the basis of their smoking or their weight. "You can't expect a person to lose 50 pounds overnight and to stop smoking at the same time," one health education expert said. "Nobody's lifestyle is perfect. If a person smokes, that doesn't mean he or she can't provide a good role model for many other things."

Principals can serve the health education program by helping determine the type and extent of inservice education teachers need and by providing teachers with instructional materials and identifying new resources for classrooms. The Association for the Advancement of Health Education would like to see principals take the following steps as well:

- Meet with health teachers and follow up on the comprehensive health education program, checking on the topics taught at each level
- Explore with community health organizations about the services and materials they can provide, including speakers and audiovisual aids
- Provide personal examples that value health
- Voice concerns about health education needs to the superintendent, board of education, and the community.

The Superintendent's Role

A superintendent's responsibilities for health education stretch out in several directions—the decisions made in the central office will affect what goes on within classrooms, in a school's general environment, and the district's health services.

It falls on the superintendent to generate local support for health education and to keep communications open between a community and its schools. To speak for the programs, superintendents must know enough about both local and national health problems to stress the need for health education. When they bring a program before the board, they should come armed with statistics and other information about health.

But superintendents should also have a clear idea of just how much health education can accomplish in their districts. They should be aware of program limits as well as the possibilities. "Sex education may not be the one great answer to teenage pregnancy, and we can't claim to eliminate smoking entirely," says Buzz Pruitt. "All we are saying is that students who have health education will be informed. You could eliminate all the health problems and still need health education in the schools, because it entails a way of life that emphasizes making healthy decisions."

Marketing School Health

Superintendents who decide to become health promotion advocates will find that there is a rich supply of public relations material available to help market the program. Some voluntary agencies and public health groups have PR materials on hand and usually want to share them. The American School Health Association, for example, publishes a kit called "A Healthy Child: The Key to the Basics" that offers samples of letters to send to state and local decision makers and model strategy plans for a community campaign. Kit materials also describe how to work with television and radio studios and tell how to write articles for newspapers about school health. The kit may be purchased for $5 from the American School Health Association, P.O. Box 708, Kent, OH 44240.

Chapter 5

Curriculum

There are ready-to-use health curricula—There are homemade curricula—There are comprehensive health programs and programs for single topics—They deal not only with facts, but also with changing behavior

When educators set out in search of a new health education curriculum or begin revising their existing one, they find an abundant supply of possibilities. The past decade has been a time of unprecedented curriculum development in the field. There are full-blown, complete curricula that span the elementary and secondary grades. There are curricula and materials that target special areas of concern—alcohol and drug education, fitness, nutrition, or family life education, for example. There is a large assortment of materials on subjects such as lung or heart health that voluntary agencies will make available to the schools, usually free or at minimal cost.

Planners have a choice when they tackle the problem—some adopt complete course offerings from other sources, and others decide that they must create a curriculum that is in part their own to satisfy local objectives.

Case for Comprehensive Curriculum

Most experts favor the comprehensive health education curriculum (from kindergarten through grade 12) because of its breadth. A comprehensive curriculum covers, at a minimum, the topics recommended by national school health authorities: community health, consumer health, environmental health, family life, growth and development, nutrition, personal health, prevention and control of diseases and disorders, safety and accident prevention, and substance use and abuse.

Not all experts agree on the virtues of such a broad curriculum, however. Len Tritsch, Oregon health education specialist, prefers a more targeted approach that concentrates on fewer issues, but covers them in depth and demonstrates the connections among areas such as fitness, nutrition, and stress management. Tritsch calls this a life management skills approach. "I've seen too many teachers rushing through a textbook and other materials, touching many topics but not tying them together," says Tritsch. A K-12 curriculum using the approach endorsed by Tritsch has been developed in Oregon and used by educators in schools there and in 29 other states. (For further information, contact Jim Terhune, 20 East 13th Ave., Eugene, OR 97401.)

Nevertheless, defenders of the comprehensive approach point to research indicating that children who have repeated exposures to key topics at different stages in their education form attitudes that help them avoid bad health habits when they are older. Consequently, comprehensive health education holds promise for affecting long-term behavior. Students exposed to comprehensive health education, including early warnings about what smoking or drugs do to the human body, are more likely to act in accordance with what they've been taught than those who have had, say, a single-focus anti-smoking or drug education program.

The solid research findings favoring the comprehensive approach have led one health education authority to say: "While one exposure to health is beneficial, subsequent exposures are even better. Teaching one year of health is good, but teaching two or more years is better."

The case for a comprehensive curriculum has unfolded gradually during the past decade as researchers began to take note of the gaps and weaknesses of single-topic curricula, such as those on smoking.

As educators studied early evaluation data from anti-smoking programs, gradually they realized that despite their most determined efforts, students were not giving up smoking. In a quest for more effective means to change bad health habits, educators began trying to reach students before adolescence—an age at which risk-taking and independence-seeking are the rule and peer pressure is more important than advice from adults; and they began to widen the range of topics.

What grew from these experiences was a conviction that broader programs, beginning early in a student's life, were needed to build a student's understanding of the dangers of bad health habits and the resolve to withstand temptation. Program designers began to work strong affective strategies into curricula that would help give students a sense of self-worth and a desire to protect their bodies from risky behavior.

In time, these strategies paid off in terms of behavior change. To cite one piece of evidence: since 1977, researchers have been following up on students in two New York schools who took the primary grades programs and then went to a middle-grade program. Results show that students who had the full health education program—kindergarten through sixth grade—have more positive attitudes toward good health practices (and more negative attitudes toward smoking) than control group students. (The study was conducted by Richard L.

Andrews and Jill Hearne of the University of Washington, Seattle, under the auspices of the American Lung Association.)

A Look at One Curriculum

Growing Healthy is one of the better-known of the nationally validated, federally (and privately) financed curriculum programs. It has been taught in at least 595 school districts in 41 states. Its content is widely recognized as first-rate, but it is still subject to improvement. Instead of a single textbook, the curriculum depends on hands-on learning experiences, learning stations, multimedia activities, individual projects, a large assortment of posters, student handouts, and other materials to get the health message across to youngsters. The materials readily integrate with those for other elementary health topics.

Many districts indicate that *Growing Healthy* has been a good investment for them. Officials at the Adams County School District, No. 12, Northglenn, Colorado, believe that the program has led to greater student interest in health and positive health lifestyles among adolescents. "Our board of education policy subscribes to a philosophy of educating the whole child—intellectual/academic, health/physical, and emotional/social aspects," says H. G. Wilson, who developed and now coordinates health education at Northglenn. "*Growing Healthy* meets our needs well."

Elk River, Minnesota, educators have been using *Growing Healthy* for five years, and Ron Burland, principal of Rogers Elementary School, is pleased. "Teachers like it," says Burland. "It's hands-on, and that energizes the kids."

Elk River has had some trouble, however, fitting all the activities the curriculum calls for into the nine-week, 45-minute-a-day slot reserved for health at each grade level. "In some cases, there's a little overkill—too much," reports Burland, who gives teachers discretion when it comes to selecting activities for their pupils.

This curriculum's demand for instructional time and its cost present problems for some school districts. In New York City, in fact, educators decided that *Growing Healthy* could be cut substantially, after they realized that virtually none of the teachers there ever completed the whole program as planned. After consulting with board of education officials, classroom teachers, and school adminstrators, the program's major sponsor (the New York Academy of Medicine) decided to cut instructional time by about one-third. The step reduced the cost for materials per grade by about one-third.

New York City has shown its enthusiasm for the revised curriculum by allocating $1.3 million for a three-year implementation. (For more information about New York City's experience with *Growing Healthy*, contact the New York Academy of Medicine, School Health Curriculum Project, 2 East 103rd St., New York, NY 10029. For general information about *Growing Healthy*, contact the National Center for Health Education's Office of School Health Programs, 1130 Burnett Ave., Suite G, Concord, CA 94520.)

"Respect and Admiration. . . ."

Another broad-based health education curriculum commanding respect and admiration is *Know Your Body*. Its target audiences are grades one through eight. Its emphasis is on student wellness through developing healthy behaviors and lifestyles. What educators like about *Know Your Body* is that it makes health education a personal, individual, relevant experience.

The information in *Know Your Body* helps students identify for themselves their positive and negative health behavior patterns. Along with health facts and concepts, the program provides experiences for developing goal setting, problem solving, decision making, and self-responsibility.

The material is divided into three levels—primary, upper elementary, and middle school—the program includes printed curriculum guides for both teachers and students as well as a film strip, test manual, and posters.

Among the stated goals of *Know Your Body* are: (1) to increase students' reservoir of health information; (2) to develop and reinforce students' positive feelings about their own bodies; and (3) to increase students' responsibilities for maintaining their own health.

To assess whether *Know Your Body* meets these main goals, research involving some 4,000 fourth- and fifth-grade students has been going on for several years. For more information about the research findings and the program itself, write American Health Foundation, 320 East 43rd St., New York, NY 10017.

For Secondary Schools

Among widely accepted curricula for secondary schools is the one known as Teenage Health Teaching Modules (THTM). It consists of 16 modules, each module designed for teaching a unit on a specific health topic and requiring between four and 15 hours of instruction. Taken together, the modules form the basis for an introductory health survey course. They can also be used separately to supplement traditional health instruction, as well as in home economics, science, social studies, and physical education.

Modules deal with such subjects as Health Is Basic (an introduction), Understanding Growth and Development, Being Fit, Eating Well, Living with Feelings, Preventing Injuries, and Acting to Create a Healthy Environment.

Educators tend to like the cost of the modules. A set costs about $200, with teaching guides, books, and student handouts included. Teachers can duplicate the material to serve an entire class. Some school districts use the modules for a semester-long health education class. Teachers can, on the average, cover five to seven modules within a semester. (Information about the THTM curriculum can be obtained from Teenage Health Teaching Modules Program, Education Development Center Inc., 55 Chapel St., Newton, MA 02160.)

And One Hundred More. . . .

More than 120 serviceable curricula are readily available to school districts for examination, study, and adaptation. They are listed in *A Compendium of Exemplary School Health Education Classroom Programs and Teaching and Learning Resources*, produced by the Centers for Disease Control, in Atlanta.

From this compendium we draw selected items covering elementary and secondary programs and illustrating the variety of topics.

Exemplary Programs: K–12

Caspar (Cambridge and Somerville Program for Alcoholism Rehabilitation), Somerville, Massachusetts. Grades 3–12. This program was developed by educators in Somerville to prepare students to make responsible decisions about alcohol use. It relies on exposure to repeated, consistent, unemotional messages about drinking through structured, student-centered school activities, formal and informal peer influence, and a positive community atmosphere. The program has been validated for national dissemination. For information: Lena DiCicco, Director, Caspar, Inc., 226 Highland Ave., Somerville, MA 02143.

School Dental Health Education Curriculum, Tampa, Florida. Grades K–12. Modules are used to educate children about proper oral health care and the availability of dental health care services. The K–5 segment consists of six modules organized by age. The middle school modules deal with preventive dentistry, oral health and disease, consumer health, and dental careers. High school modules cover consumer health, career education, and the parent's role. For information: Robert M. MacDonald, Assistant Executive Director, Florida Dental Association, 3021 Swann Ave., Tampa, FL 33609.

Health Education Risk Reduction, Normal, Illinois. Grades K–12. This is a multi-faceted project combining community health and educational agencies to support and carry out activities that should reduce health risks among school-age children. Risk areas include obesity, smoking, alcohol abuse, lack of exercise, stress, and hypertension. For information: Ann E. Nolte, Health Education Program, Department of Health Sciences, 103 Moulton Hall, Illinois State University, Normal, IL 61761.

Health Skills for Life, Eugene, Oregon. Grades K–12. This comprehensive program emphasizes lifetime health skills and the application of knowledge in ten major content areas. It consists of 118 separate teaching packages, each of which deals with a separate skill. Educators can select those that meet their community's needs. For information: James A. Terhune, Health Skills for Life, 20 East Thirteenth Ave., Eugene, OR 97401.

Healthy Mothers, Healthy Babies, White Plains, New York. Preschool through high school. This March of Dimes-funded curriculum, prepared by the Association for Supervision and Curriculum Development, stresses the things students need to know to promote healthy childbirth and responsible parenthood. Materials include a 64-page guide and a chart outlining key concepts and objectives at each grade level. For information: Robert Goldberg, Assistant Director, March of Dimes Birth Defects Foundation, 1275 Mamaroneck Ave., White Plains, NY 10605.

"Here's Looking at You Two," Seattle, Washington. Grades K–12. Through different activities at each grade level, this curriculum provides students with facts about alcohol/drug use and abuse. It helps them develop decision-making skills, methods of coping with problems and better self-concepts. Teachers can present "Here's Looking at You Two" as a special unit or integrate the learning concepts into traditional subject areas. For information: Roberts and Associates, 9131 California Ave. S.W., Seattle, WA 98136.

Lincoln School Health Education Program, Lincoln, Nebraska. Grades K–6, 8, and either 10, 11, or 12. The elementary level program aims at helping children develop good health habits and attitudes by providing them scientifically-based knowledge and by incorporating good health practices into the regular routine at school and at home. Materials use a discovery approach and integrate into other subject areas. The senior high section concentrates on preparing students to think critically about their health and community health problems. For information: Dean A. Austin, Consultant for Health and Physical Education, Lincoln Public Schools, P.O. Box 82889, Lincoln, NE 68501.

Nutrition Education and Training Program, Columbus, Ohio. Preschool–grade 12. This curriculum was developed by the Ohio Department of Education. The contents integrate nutrition with activities for developing basic skills in math, social studies, language arts, science, and health. The cafeteria is treated as an integral part of the educational process, a learning laboratory where students practice making food choices. For information: Harold Armstrong, Coordinator, Nutrition Education and Training Program, Ohio Department of Education, 65 South Front St., Columbus, Ohio 43215.

Project Prevention, The Dalles, Oregon. Grades K–12. This curriculum provides students with prevention skills, including those that concern decision making and communication. It can be adopted in its entirety, but aspects can be integrated within an existing health program. Objectives include developing self-concept, applying first aid, understanding human growth and development from conception through death, making decisions and communicating in stressful situations, and locating health resources and services. For information: Howard Gonser, Project Director, Chenowith School District, 3632 West 10th St., The Dalles, Oregon 97058.

Providence Plan for Improved Health and Nutrition, Providence, Rhode Island. Grades K–3. This curriculum consists of a series of sequential lesson plans covering structure and function of the human body, nutrition, dental health, and mental health. Lessons can be integrated into language arts, math, social studies, and science. For information: Louis A. Marciano, Chief, Office of Health Promotion, Rhode Island Department of Health, 103 Cannon Building, 75 David St., Providence, RI 02908.

Exemplary Programs: K–8

Drug/Alcohol Education Program, Conway, Arkansas. Grades K–6. Purposes of curriculum are to develop a positive self-concept in young students and provide them with information about drugs and how chemicals affect the body. It emphasizes maximum student participation. For information: Department of Health Education, University of Central Arkansas, P.O. Box 1776, Conway, Arkansas 72032.

Health Activities Project, Berkeley, California. Grades 4–8. This program starts students thinking about their health and safety through hands-on, discovery-type activities. Its main purpose is to make them more aware that they can control what happens to them. For example, students learn to measure blood pressure, make plaster impressions of their teeth and monitor air for dirt and dust. For information: David R. Buller, Director, Health Activities Project, Lawrence Hall of Science, University of California, Berkeley, CA 94720.

Health Education Curriculum, Canton, Ohio. Grades K–6. This curriculum provides comprehensive health education to students that fosters lifelong values regarding physical, mental, and social health. The six major content areas are: Family Living; Growth and Development; Drugs, Alcohol, and Tobacco; Safety; Environmental, Community, and Mental Health; and Nutrition. For information: Margaret Kirkpatrick, Director, United Way Health Foundation, 618 Second St. NW, Canton, OH 44703.

Project CHEK, Comprehensive Health Education for Kids, Lansing, Michigan. Grades K–8. At the K–5 level, this program offers a full year of learning activities covering ten major topic areas of health. The topics are arranged in five modules that are repeated in a sequential format at each grade level. Each part of the 6–8 program has its own set of objectives and builds on the K–5 model sequentially to cover the ten topic areas. For information: Delores Unsicker, Project CHEK, Department of Health Education, Wayne State University, Detroit, MI 48202.

Exemplary Programs: 8–12

Self-Discovery, Boston, Massachusetts. Grades 8–11. This is a program for junior and senior high school students that is reinforced by family and community activities. Its structure is flexible and can be adapted to meet the needs of the school and community. It contains motivating strategies with factual information to help teenagers expand their range of positive health choices. For information: Carol Bershad, Project Director, Learning for Life, Management Sciences for Health, 165 Allandale Road, Boston, MA 02130.

Skills for Living (Project of the Quest National Center), Columbus, Ohio. Grades 9–12. The Quest curriculum, a companion book for students, and student journals form the core of this program. It is based on what 2,000 high school students said concerned them most in life. It focuses on helping students and parents learn basic skills in problem solving, communication, self-esteem, and conflict resolution, and teach them to apply these skills to areas of concern identified in the student survey. For information: Rick Little, President, Quest National Center, 4360 Maize Road, Columbus, OH 43224.

What Local Districts Do

A recurring challenge for local health program developers is to fit the bits and pieces of material that come from many different sources together in a coherent, sequential whole. "The number of health problems deserving consideration in the classroom has become so great," says the Association for the Advancement of Health Education, "that these teaching aids and materials often interfere with the development of a comprehensive and sequential health instruction program."

Many districts have successfully overcome this hurdle. At Central Kitsap School District in Silverdale, Washington, curriculum specialists, school nurses, and teachers joined forces to develop a compact package—a K–6 curriculum covering physical health, mental health, environmental and community health, safety, self-image, nutrition, drugs, body systems, and

Note: Inquiries about these programs and others contained in *A Compendium of Exemplary School Health Education Classroomm Programs*, should go to Roy Davis, Centers for Disease Control, 1600 Clifton Road, NE, Atlanta, GA 30333. The office will lend copies of the *Compendium* for photocopying.

human growth. The school nurse gave the teachers advice on health content, curriculum personnel defined the learning objectives, and teacher committees organized by grade level shaped the materials into units.

Every summer, teacher committees at Silverdale, an 8,700-pupil district, revise the curriculum. "Curriculum development is never finished, it's always in process," says David Rawls, who oversees the health curriculum. He adds this bit of advice for curriculum planners: If you're going to have different teacher teams writing the units, define the scope of each unit before writing begins. This should avoid overlap.

A sampling of products: No uniform pattern appears as to what schools are emphasizing, according to the AASA survey of school district programs. As further examples:

- Educators at the Northern Valley Regional High School in New Jersey recently developed a new curriculum guide that outlines objectives for K–12 general health and outlines content for a family life education program.
- Manatee, Florida, educators reviewed their sixth grade curriculum after a study of the middle schools and recommended 12 weeks of health instruction in sixth, seventh, and eighth grade. The board of education also authorized creation of a K–12 human growth and development sequence. Besides sixth grade health, Manatee students study venereal diseases in seventh grade and cardiopulmonary resuscitation (CPR) the following year. The district also has developed a Health-Life Management high school course and a guide for teaching about sexually transmitted diseases (for grades seven and ten).
- Avon, Connecticut, school officials have produced a new K–9 offering that presents wellness concepts to students
- Saginaw, Michigan, city schools have begun implementing a model health education program and revised a health and life science course taught in eighth grade.
- In Greenfield, Wisconsin, educators have been concentrating on a new course for seventh grade that covers smoking, self-awareness, digestion, nutrition, and weight control, and a course for eighth graders that stresses drugs, alcohol, and communicable and noncommunicable diseases (including venereal disease).
- In Clay Center, Kentucky, a rural district with no health education coordinator, the school lunch director developed units of study on nutrition.

Sequencing Topics

Most districts that have produced comprehensive curricula generally use a spiral approach, in which different strands that represent health education topics dominate instruction at one grade level and then become submerged, to surface again. These educators choose topics primarily on what students most need to know at a given age. However, they also often consider what students are most interested in at various ages. Paying attention to students' interests, experts say, helps make health a vibrant and lively subject that students want to study. They take health because it has intrinsic value to them, not because they think health is a snap course.

In the kindergarten: In the primary grades, where interest in body growth and development runs high, for example, children usually learn about personal health and hygiene, including dental health. Since young children need to know how to cope with emergencies, safety, accident prevention, and first aid are usually introduced, too, along with nutrition and initial warnings about the dangers of substance abuse. Educators say that giving children information about health dangers at this age will help shape the attitudes and behavior they will display when they are old enough to be at risk. Many think that kindergarten is none too soon for introducing this type of information. Education for good mental health also begins when children are very young, and teachers usually try to instill strong, positive self-images in kindergarten or first grade.

Teaching in grades one and two often deals with family life and friendship. Some programs begin introducing environmental health and community health information at this point. Instruction in physical fitness and nutrition frequently starts here, and children are encouraged to make regular use of health services, including their family dentist. Topics such as personal health and safety remain important: for example, the curriculum at Forest Hills School District in Cincinnati, Ohio, calls for teachers to educate first graders about auto seatbelts.

About sleep and rest: By grades three and four, curricula usually start dealing with body development. Third graders learn about bones and muscles, while children one year older study cells. Students this age may also be introduced to the importance of sleep and rest, nutritional food groups, and communicable diseases. Adolescent growth and body changes that accompany it are often major topics for fourth graders, too, and warnings about substance abuse may be repeated in a more sophisticated form.

On the sources of stress: By sixth grade, many students are learning how the human reproductive system works, and school programs often start trying to develop a better understanding of mental health. Many school district programs deal with peer pressure and stress at this age. Fifth graders in many schools learn relaxation techniques. In Oregon, students start learning to identify sources of stress that trouble them (sometimes Oregon teachers introduce these topics when children are even younger). Other sixth grade programs highlight safety measures such as rescue breathing and helping choking victims. Warnings about drug abuse and other bad health habits may also be repeated in middle school years.

For the middle years: Seventh and eighth grade health students often keep on learning about reproduction, substance

abuse, family life, nutrition, and personal hygiene. Junior high school is, in many districts, the time for introducing information about sexually transmitted diseases. Eighth graders at New Jersey's Northern Valley Regional learn about syphilis, herpes, human fertilization, and pregnancy.

School programs also often try to deal with students' natural tendency to take more risks as they reach upper elementary or junior high school classes. Teaching strategies, therefore, aim at developing good decision-making and problem-solving skills that students need if they are to accept responsibility for personal health behavior.

The spiral continues: At the high school level, some districts offer a general health course covering many topics. A life-management skills course at the Kissimee, Florida, schools, for example, includes instruction about good emotional health, nutrition, substance abuse prevention, breast self-examination for girls, consumer education, and the proper ways to use health services. The program also contains a strong antismoking component.

A Saginaw, Michigan, human ecology course covers a similar field: consumer health, care of the body, nutrition, mental health, substance use and abuse, disease prevention, chronic health conditions, environmental and community health, accident prevention, and family life education. Some secondary school programs contain special suicide prevention components for high school youngsters.

Sex education continues during the high school years at many school districts, offering 11th grade courses on sexual behavior and expression, myths about sex, family planning, and birth-control measures. Some districts also have courses for expectant mothers or other students who want to know more about parenthood. The courses, typically electives, deal with such things as prenatal care, parenting and family life, resolving conflicts, and infant nutrition. Frederick County, Maryland, has a parenting class at every secondary school in the district.

Resources and Other Materials

A sampling of replies to AASA's survey indicates a wealth of materials available from sources outside the school for locally-developed course offerings.

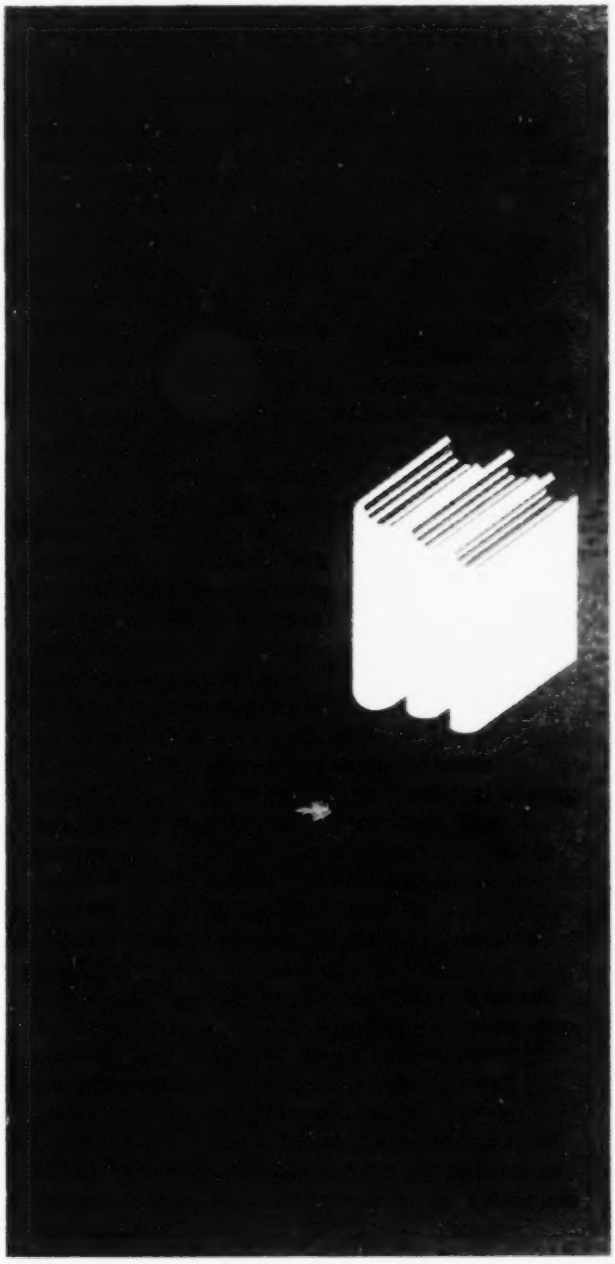
Kissimee, Florida, educators, for example, got help from the American Cancer Society for teaching breast self-examination, local doctors there help teach a fifth grade personal development program for boys, and local mental health personnel assist with a high school parenting and personal development course.

The Wichita Falls, Texas, schools drew upon resources from the American Red Cross, the American Lung Association, the American Cancer Society, and other groups for their curriculum.

In Montgomery County, Maryland, the county chapter of the American Cancer Society provided kits and instructional materials for the schools.

The county health department helps schools with an alcohol and drug abuse program in the Frederick County, Maryland, schools.

Delano Union Elemenatry School, Delano, California, got help with aerobic exercise and nutrition programs from the local recreation department.



Many districts report that materials from the American Heart Association and the American Lung Association have proven to be particularly valuable. Lung association materials form the basis for an elementary school lung health curriculum used in the New Haven, Connecticut, schools—the association donated teaching kits for every elementary school and also held workshops for teachers. Many other districts offer heart health curriculum units based on heart association resources and some get materials for sex education programs from Planned Parenthood. Business groups, such as the National Dairy Council, also provide useful resource materials, according to the AASA survey.

RESOURCES GALORE

Not so long ago, U.S. Public Health Service officials looked at the mass of health education materials pouring out of the nation's voluntary private-sector agencies concerned with health. What they saw was a flood of materials "badly segmented, fragmented, categorical, and often counter productive."

To correct this, the U.S. Public Health Service encouraged 14 major agencies to take "a common approach," to find ways for a long term view about the development of educational materials. Further, the Public Health Service urged the voluntary agencies "to produce items that will fit into comprehensive packages, rather than turn out single categorical information pieces.

One result of this effort was the production of four large charts (33 by 24 inches each), listing and describing comprehensive packages that include printed materials, audiovisuals, posters, charts, and teacher references. The packages cover personal health promotion, mental and emotional health, family health, drugs, alcohol and tobacco, nutrition, community and environmental health, first aid, and safety.

The four charts are scheduled for periodic revision and updating. For information about the charts, write the Centers for Disease Control, 1600 Clifton Road NE, Atlanta, GA 30333.

In some instances, it may be useful to write directly to any one of the 14 voluntary agencies. Their names and addresses and what they offer are given below. The local unit of chapter of associations is usually listed in the yellow pages of the telephone book.

American Academy of Dermatology (AAD)
Print Materials: Single copies free from:
American Academy of Dermatology
8120 Davis
Evanston, IL 60201

American Academy of Pediatrics
Print Materials may be purchased from:
141 Northwest Point Boulevard
Elk Grove Village, IL 60007

American Cancer Society (ACS)
Print Materials available from your local unit.
Most materials are free in limited quantities.
Audiovisuals and *Teaching Kits* may be available on free loan from your local unit.

American Dental Association (ADA)
Print Materials: Single copies free from:
American Dental Association
Bureau of Health Education & Audiovisual Services
211 E. Chicago Avenue
Chicago, IL 60611
Units (Program Packages) may be purchased from ADA.
Audiovisuals on loan from Modern Talking Pictures or rental from ADA.

American Diabetes Association (ADA)
Print Materials available from your local chapter.

American Heart Association (AHA)
Print Materials available from your local chapter.
Many materials are free in limited quantities.
Audiovisuals may be available on free loan from your local chapter (or may be purchased through it).

American Lung Association (ALA)
Print Materials available from your local chapter.
Many materials are free in limited quantities.
Module (program package) may be purchased from local chapter.
Audiovisuals may be available on free loan from your local chapter.

American Medical Association (AMA)
Print Materials: Single copies free from:
American Medical Association
Department of Health Education
535 N. Dearborn Street
Chicago, IL 60610

American Medical Association Auxiliary (AMAA)
Single copies free from:
American Medical Association Auxiliary
535 N. Dearborn Street
Chicago, IL 60610

RESOURCES GALORE

American Optometric Association
Print Materials: Single copies free; send self-addressed stamped envelope to:
American Optometric Association
243 Lindberg
St. Louis, MO 63141

American Pharmaceutical Association (APA)
For information about purchase cost, contact:
American Pharmaceutical Association
2215 Constitution Avenue, NW
Washington, DC 20036

American Red Cross (ARC)
Print Materials and *Program Packages* available from your local chapter. Contact for purchase information.
Audiovisuals available on loan from local chapter.

American School Health Association (ASHA)
Print Materials may be purchased from:
American School Health Association
P.O. Box 708
Kent, OH 44240

Association for the Advancement of Health Education (AAHE)
Print Materials and *Audiovisuals* may be purchased from:
AAHE
1900 Association Drive
Reston, VA 22091

March of Dimes, Birth Defects Foundation (MOD)
Print Materials available from your local chapter. Many materials are free. If no local chapter, write:
MOD
Public Health Education Department
1275 Mamaroneck Ave.
White Plains, NY 10605

Chapter 6

Staff

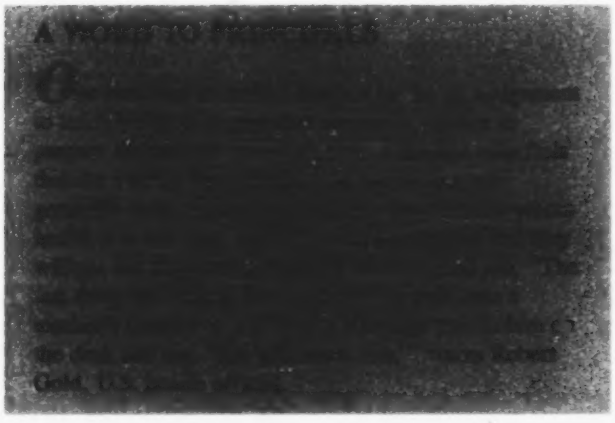
Competency for teaching health education topics depends on staff development, training, retraining—The health coordinator plays a role—So do community resources, colleges and universities—And students

No aspect of their professional life seems to disturb health teachers more than the assumption (by some educators) that any teacher—with or without a strong health background—can handle health instruction. There are more unqualified teachers teaching health than any other subject, health education spokesmen say. This is a condition fraught with risk, because health education has its own special content that must be treated with care.

Much of the health education content has surfaced during the past two decades; new knowledge about health comes continually. That is why health educators need up-to-date training that prepares them to master this material. "If we were assigning social studies to a teacher, would we assign the subject to a person with minimal professional preparation and interest?" asks Chet E. Bradley, health education supervisor for Wisconsin. "No, we wouldn't. Nor should we assign health education to people with the minimum."

Nonetheless, in many districts, individuals with no training in health stand in front of classes teaching consumer health, environmental health, drug education, disease prevention, nutrition, and sex education. This is not the route to quality health education, spokesmen for the field insist; to achieve that, districts must hire fully qualified health educators. "Finding the very best people you can employ is the only way to go," says Bradley. "An outstanding program comes from outstanding leadership and teaching."

Another problem—lack of coordination—also besets many school health education programs. Since health content is likely to be parceled out to teachers whose main interests lie in other subjects, no one may be keeping track of a district's total health education activities. But someone *should*—to make certain that what is taught in the different classrooms adds up to a comprehensive program.



The Health Coordinator's Job

This is where the health coordinator comes in. A health coordinator's responsibility may blanket many areas: developing curriculum, teaching students, leading staff committees, helping with evaluation activities, and sometimes either overseeing or carrying out the health services program. In districts where the school nurse is the expert on health education, he or she may double as the health coordinator.

Coordinators also usually have responsibility for keeping teachers' health knowledge up-to-date through inservice training. It is not easy for teachers, especially those who aren't health specialists, to keep up with new developments in health education. No single organization or journal encompasses the entire field, and required reading takes in not only health education journals but publications devoted to fitness, nutrition, sex education, and drug education. "The average classroom teacher cannot keep up," says Liane Summerfield of Marymount College, Arlington, Virginia. "It's hard even for health educators to keep up. The health coordinator can help."

If the health coordinator is a district's only trained health educator, that person usually ends up with a host of assignments. In North Carolina, where the state provides money for local district health coordinators, the job is year-round, carried out by personnel who are required to:

- Coordinate the use of local resources in the school health education program
- Review, test, and procure health education instructional materials
- Provide health education inservice training
- Develop and carry out comprehensive health education at all grade levels
- Plan with local health education or resource agencies and with organizations and institutions of higher learning

- Evaluate the local school health education program
- Prepare annual plans and budget reports for the department of public instruction
- Work cooperatively with the local school health council.

Part of the coordinator's job in North Carolina is digging out community resources on health topics and distributing the material to teachers. Further, health coordinators organize inservice training, not just for teachers, but also for administrators and community volunteers. Coordinators also help select textbooks—North Carolina offers districts a choice of three series at both the elementary and the secondary levels.

Coordinating the Program

In other states, health education coordinators have similar responsibilities, with inservice training, curriculum, and community liaison duties high on the list. Health advocates say there should be a health coordinator in every school building, as well as at the district level, but they recognize that may be asking "for too much, too soon."

Says Robert Gold: "Certainly the ideal is to have a full-time health educator in all or most elementary and secondary schools. But the principal may fall back on assigning a math teacher, for example, to teach one class of health a day. I won't argue against this, as long as the principal provides opportunities—materials, guidance, and training—for that teacher to do well in that class; and further, that the principal makes a commitment to support health education."

A cardinal principle recommended by health education leaders is this: Someone should be in charge of health education, even if he or she has other responsibilities. In the Elk River, Minnesota, school district, teachers at Rogers Elementary work as teams at each grade level, with one member serving as team leader. Diane Strege, fourth grade team leader, says that a big part of that job is to gather the materials for instruction before teachers start the year's work. Strege runs off worksheets ahead of time, distributes the necessary materials to other team members, and sits down with them to talk over what to do next. She gets no extra salary for these services; in fact, teachers take turns as team leader to even out the work load. "It's a big job," she says.

No matter who ends up coordinating the elementary program, that person should have a genuine interest in health education. Program evaluators have pointed out that whether a teacher is interested in the subject makes a difference in how much students learn.

Training Teachers

AASA survey respondents often reported that they have trouble finding qualified staff. Teachers who are not qualified must be trained for the tasks. Further, it is often necessary to raise the teachers' appreciation of the importance of health education. Many elementary teachers do not have this appreciation, and their attitude creates a major problem in promoting health.

How much training do teachers need to carry out adequate health education? The School Health Curriculum Project called for teachers at each grade level (four through seven) to attend a 60-hour workshop. The Primary Grades Health Curriculum Project required a 30-hour workshop for teachers. In both projects, school staff were trained as teams, usually composed of classroom teachers from the same building and grade level, the building principal, and one or two additional support people—nurses, curriculum supervisors, librarians, or audiovisual specialists. Two teachers from each grade level were included so that if one left the district, his or her colleague could continue.

Inservice in Arkansas and Michigan

In Arkansas, where the state departments of education and health and the University of Central Arkansas are helping teachers get ready for new state health education standards, team training is the rule. Arvil Burks, a health educator at the university in Conway, says that when a new training project begins, superintendents and principals are contacted about attending even before teachers. "It is vital to gather their support before beginning to work with teachers," Burks says.

Under the new state standards, Arkansas schools must provide some health lessons in all elementary grades. At least nine weeks of health must be offered in grades seven and eight, and a half-credit is offered to high school students. Arkansas teachers are also gearing up to teach family life education, and a local district school board member and a parent are invited to participate in training sessions for teachers.

The most difficult problem for Arkansas teachers, says Burks, has been a lack of knowledge about health content, especially among teachers of physical education, home economics, and academic subjects. Five-day workshops (that counted as college credit) helped alleviate that problem.

In Michigan, where many districts are also gearing up to teach a model comprehensive health education curriculum (kindergarten through grade eight), inservice training is also of considerable assistance. "I don't think elementary teachers could function without training," says Wanda Jubb, health education specialist for the state education agency. Michigan is relying on regional health coordinators to help districts carry out the new curriculum. Coordinators receive four days of training for the kindergarten-through-grade-three curriculum and three days of training for grades four through

six. They, in turn, train local district teachers, giving them about 30 hours of instruction.

When More Time Is Needed

The amount of time and the type of training teachers need will vary. If a program focuses on behavior change, it may require different training methods from those used to impart knowledge. In Oregon, Len Tritsch employs several different delivery systems for inservice training. "If you're going to deal with information," says Tritsch, "then short one-hour sessions might be fine. If you're going to get into skill development and attitudes—for instance, if you are going to change the nutrition practices and policy in a district—you'll have to deal with more than content. You need a longer period of time—three hours or more for each workshop."

School districts should always build in teacher training components when developing and introducing new health content. The New Haven, Connecticut, schools recently offered ten workshops for teachers on health education topics that were new in the curriculum. The workshops covered such topics as peer friendship patterns, safety risks for adolescents, child and young adult dental motivation, physical fitness, nutrition, adolescent suicide, and helping children cope with stress created by situations such as divorce and remarriage of parents.

Districts often turn to county and voluntary agencies, hospitals, or universities for help with inservice training. New Haven workshop leaders included a local dentist, a pediatrics instructor at Yale-New Haven Hospital, the coordinator of a local child sexual abuse project, and Planned Parenthood staff, for example. In addition, the New England Dairy and Food Council conducts 10 to 15 workshops a year for New Haven health education teachers.

Peer Education

One further source of health education personnel should be noted. Some schools use peer educators—students who counsel other students—very effectively. Since peer relationships influence some of the most important health decisions that youngsters make, this resource should not be overlooked.

In Cayce, South Carolina, for example, students who have had health education and have some training in counseling run a health information and counseling center for high school students. Peer strategies are sometimes used in antismoking programs and in activities that address substance abuse. In Des Moines, Iowa, students help others their age deal with drug use, peer pressure, and personal communication. These students have also worked with youngsters in elementary and junior high school. Peer educators often are effective with younger students. In Roselle Park, New Jersey, the schools run a program called Roselle Park Trust Company. High school students serve as big brothers or big sisters to elementary school students, many of whom are considered problem children. The youthful counselors concentrate mainly on developing younger students' self-esteem. In Huntington Park, California, members of Youth Gives a Damn, a coalition of high school health clubs, holds an annual health camp for students throughout the state.

Schools often provide training for peer educators. To join the leadership classes, students must have good grades and a teacher's recommendation. Sometimes students get credit for their counseling and educational duties. The Bostwick, Florida, schools gave students who helped with a smoking and alcohol education project half a credit toward high school graduation.

Chapter 7

Action

A casebook of action reports from a sampling of school districts—Experiences of administrators with community advisory groups, health coordinators, workshops for staff wellness—Reports from East, West, North, and South

Beaver Dam, Wisconsin

"Not about blood and bones alone. . . ."

The district's push toward a better health education program began about ten years ago and has had the backing of key administrators all along. While many Wisconsin districts made health an elective in high school (under state-adopted standards), Beaver Dam made the subject a requirement. "It gave us an avenue to pull together all our concerns—alcohol and drugs, suicide, all the contemporary problems of youth—under one umbrella," explains Richard Fitzpatrick, principal of Beaver Dam high school. District administrators also started to work on the elementary school health education curriculum, with Fitzpatrick coordinating the overall effort.

Says Fitzpatrick: "Many school people still think of health education as being about blood and bones. They don't realize that it is about contemporary issues."

Working with the local cooperative educational service agency, Fitzpatrick ordered guides and materials from across the U.S. and put them together in a three-inch-thick manual. "It was much more than anyone could implement," he says, "but it gave our people a chance to pick and choose."

Fitzpatrick and the teachers used summer curriculum time, paid for by the district, to develop and refine the health education materials. Some money also came from the district's funds under the various titles of federal educational laws. "I was always out there with my hand out, watching out for title money that was not yet allocated," Fitzpatrick recalls. The current program costs approximately $50,000 a year—out of a total annual budget of $11,000,000 for the district, which serves 3,000 pupils in rural Wisconsin.

Present health coordinator Steve Jaeger continues the search for new ideas and materials to keep the curriculum up-to-date. The most recent addition is a one-half credit junior high school course taught in both the seventh and eighth grades. The course covers alcohol and drug abuse, first aid, and keeping in touch with feelings and emotions—an area that Jaeger feels is important in light of the rising teenage suicide rate.

In high school, health education consists of units on physical health and wellness, disease prevention, mental health, alcohol and drug abuse, first aid and cardiopulmonary resuscitation, family life, and sexually transmitted diseases. Included also is a unit acquainting teenagers with the problems of aging.

When the district began organizing the elementary school health program ten years ago, teachers were reluctant to start using the curriculum's human sexual strand. Beaver Dam School officials took care to guarantee that the program would have community support, using continuous communication with parents to accomplish that goal. Meetings with parents usually drew large crowds. Parents were encouraged to look over the curriculum materials and to express their views. This preparation paved the way for community acceptance, and the sex education program eventually won local support. "We hear horror stories from other districts," says Jaeger, "but I've never gotten any negative comments."

At present, Beaver Dam kindergarteners and first graders get 35–40 minutes of overall health instruction each week during the school year, while children in the third through the sixth grades study health 40–60 minutes per week. Secondary school students must accumulate a full credit of health education before graduation.

Beaver Dam administrators also have turned their attention to policies concerning school emergency procedures. Board policy is spelled out in a 35-page document and includes instructions on how to cope with sudden crises (choking, hyperventilation, heart attacks, heat exhaustion, bleeding, poisonings, and many others). Copies go to every teacher and must be taken on field trips, along with a first aid kit. The district drew up the regulations after consulting with the county nursing agency and the Dane County Medical Society.

The booklet describes the regulations for school nursing care, explaining where emergency rooms should be located and what supplies and information should be kept there. Furthermore, it explains under what circumstances the rescue squad should be called, and when, instead, it is sufficient to send a sick child home. One section covers rules for dispensing medicines to students.

Beaver Dam administrators believe that the general emphasis on health has rubbed off on school staff members. Few of them smoke now, according to Jaeger. Several kicked the habit during the past two years.

Jaeger is convinced that developing a local health education

curriculum, as opposed to adopting one from outside sources, has its advantages. "The major value in building our own, especially at the elementary level, is that each person who is involved becomes an advocate," he explains. "They have a sense of ownership. Teachers in the lounge can be more effective than the best salesperson." He has two tips for other administrators venturing toward a health education program:

- Go slowly, and keep administrators and parents informed at all times
- More than anything else, health education leaders must be respected and should lead lives that set an example. "The messenger is the message."

(For further information, contact Steve Jaeger, Beaver Dam Senior High School, 500 Gould St., Beaver Dam, WI 53916. The district will make curriculum guides and other materials available to educators for a fee.)

Genesee, Michigan:

How to work with a health advisory group

What is it like to work with a community health education advisory group?

For Gloria Bourdon, co-coordinator of health education for the Genesee, Michigan, Intermediate School District, working with a local advisory group has been a rewarding experience. "At first, there was a problem with people protecting their own turf," she recalls. "But after 15 months, we're working together." As evidence of cooperation, Bourdon points to a resource book that group members put together for the health education program and a health fair. The book lists names of potential speakers, plus their phone numbers, and the hours they are available to speak at schools. Speakers are categorized under the ten topic areas they are best qualified to cover. The health fair has been acclaimed a success for promoting health in the community.

Sitting with Bourdon on the advisory group are leading figures of local public and private health agencies, along with a parent and a principal. Members from local health agencies include the director of the Mott Children's Center, which provides health services to needy children, and a representative from the dairy council, the county public health and mental health offices, the heart, lung, and cancer voluntary organizations, the Red Cross, the local substance abuse agency; and representatives of three hospitals.

Because of the diversity of people and their own problems, "you have to be very diplomatic in conducting discussions of the advisory group," says Bourdon. "Don't try to stick strictly to the topic of comprehensive health education in your discussions at all times." One technique that worked with the Genesee group was to set aside some time at each meeting when agency representatives could talk about *their own interests*. Giving members a chance to participate as representatives of their agencies also helps smooth group relations. In Genesee, each advisory committee member has an opportunity to speak on topics that are particularly pertinent to his or her agency at monthly inservice sessions for teachers. "They can tell the teachers what their agency offers," she explains. "It's a process of exchanging information."

Then, too, it's a help if all the members can work on a common project. A health fair fulfills that purpose in Genesee. The fair began about four years ago as a nutrition exhibition. During 1985 it was expanded with the help of the advisory group to cover the range of topics that go into comprehensive health education.

At the fair, each agency representative has a table where he or she can display materials and resources. Each table is provided with chairs, where visitors can sit and listen as the representative talks on a topic of his or her own choosing—the Red Cross members talked on the needs of latch-key children, for example, and the substance abuse representative spoke on teenage drinking. Every 30 minutes, guests rotate to a different table; visitors are told to plan on hearing the four presentations they most wanted to attend.

"The fair takes a lot of planning," Bourdon says, "But after four years, we have it down to a science."

(For additional information on Genesee's health promotion program, write Gloria Bourdon, Genesee Intermediate School District, 5075 Pilgrim Road, Flint, MI 48507.)

Cleveland County, North Carolina:

One person's achievement—raising level of health

What happened in the Cleveland County, North Carolina, Public Schools since Jimmy Hines went into action there as school health education coordinator proves how much difference one individual can make for a district's program. Hines took the health coordinator's post during fall 1979. Although he was hired by the local board of education, the state of North Carolina pays his salary.

In the 9,000-pupil district, Hines's impact reaches many areas. "First and foremost, he has raised the school system's level of awareness about the importance of health education," says superintendent Mickey Church, "especially as to what can be done in preventive ways—physical and mental health. He is adept at getting health education on the agenda at principals' meetings so that they will take it back to their teachers."

As soon as he was appointed health coordinator, Hines began spreading his message. He spoke before meetings of parents and community groups to raise overall awareness of good health practices. He also organized a school health council composed of doctors, nurses, teachers, personnel

from various county agencies, and other community leaders. The council determined that the district's most pressing health education needs were: better mental and emotional health instruction; additional family life education; and opportunities to learn more about health fitness and ways to prevent chronic health problems.

Hines set to work putting a comprehensive K-12 health curriculum into place. He developed a curriculum guide (adapted from the North Carolina state framework for health education) that quickly won school board approval. Instruction concentrates on improving students' abilities to make decisions about their own health; on making the youngsters aware of positive and negative factors that might influence their health; on increasing understandings of sources of stress and characteristics that affect people throughout their lives; and on encouraging them to follow good lifestyles, while discouraging health risks.

Hines also turned his attention to determining what district teachers needed. Their response: They wanted better resource materials for teaching. Hines rounded up suitable materials on nutrition, family life, safety, and other topics and set up a health education clearinghouse on health education resources.

But teachers also needed training to use the new instructional tools. Hence, staff development became a high priority for Hines. Teacher training activities for Cleveland County teachers have included:

- Training for elementary school teachers and food service workers in nutrition, as part of the federally financed (and state disbursed) Nutrition Education Training Program. Hines works with the food service director to arrange for healthful school breakfasts and lunches.
- A workshop for fifth grade teachers with the title "What's the Harm of Smoking?"
- A 10-hour drug education workshop for kindergarten through fourth-grade teachers on medicines in the home, prescription drugs, and poisons.
- An inservice session that showed first grade teachers how to teach seatbelt safety.
- A program for junior high school teachers on applying the "Hug of Life" technique to save people from choking. Teachers taught the technique in their classrooms and youngsters who mastered it earned certificates.
- A session on cardiopulmonary resuscitation for junior high school teachers.

To get some of the new health education activities rolling, Hines goes into the classroom himself. One year, he led an alcohol education program for second graders, for example, while regular teachers observed. This program proved to be especially popular with parents. Another program for young children has also produced good results. When first graders visited a local pediatric hospital, he says, the experience eased their fear of hospitals.

In 1981, Hines introduced a one-semester high school health class, in which he explored personal health issues for tenth graders. After a semester, he invited physical education teachers to observe the class and take part in teaching it. Says Superintendent Church: "This went over very well with both the teachers and the students."

(For more information about Jimmy Hines's work as a school district health coordinator, contact the Cleveland County Schools, 130 South Post Road, Shelby, NC 28150.)

Muscogee County, Georgia:

From a small beginning to a major project

In the late 1970s, high school science teacher Ronnie Shehane noted that much of Muscogee county's health instruction was in the hands of coaches, who often tended to be more interested in sports than health. With no offense to coaches, Shehane became convinced that health would fare better if science teachers were handling the subject. Along with other Muscogee teachers, Shehane designed a K-12 program for doing just that. Social studies and home economics teachers joined the science teachers in carrying out the program in secondary schools.

This curriculum rests on measurable objectives. Called the Muscogee Health Project, it has been approved for dissemination by the National Diffusion Network. According to an official description, it is relatively inexpensive to implement and depends mostly on materials that school districts are likely to have on hand.

While the secondary program was being developed, Muscogee County's elementary science consultant, Elizabeth Thornton, and others in the district began to feel that more should be done to strengthen health education in grades four through six. Consequently, Thornton led a group to begin writing a curriculum for a cardiopulmonary fitness program called the Health Improvement Plan (HIP). This plan presents information to children about diet, physical fitness, and general good health and prepares them to take responsibility for their own health behavior.

Classroom instruction emphasizes medical risk factors, in grade four, nutrition in grade five, and blood pressure and cardiovascular health in grade six. The material is written to merge with the Muscogee Health Project. When HIP activities are warning students about health risk factors, the youngsters also are studying body systems in their health-science program.

HIP continuously stresses the importance of good health behavior and the individual's responsibility for maintaining it. The nutrition component, for example, works on changing children's tastes. Cafeteria staff use classroom "tasting parties" to get children to sample dishes that might not be their first choice on the school menu. A food service worker might bring a new dish—for instance, squash mixed with cheese—

into a class, explain its nutritional value, and show the students that it tastes good.

Teachers have also led a foray against animal fat, especially pork, that seasons so many homestyle Southern dishes. They held an inservice session on the subject for cafeteria workers and cooked up dishes of greens seasoned with bouillon for their classes. "Kids often help with cooking at home," says Thornton, "and we feel we can make a real difference this way."

Muscogee's health promotion is working. "We've almost eliminated chocolate milk from the cafeteria," says Thornton, "and there are no salt shakers on the tables." Students are also showing interest in fresh fruit, rather than baked desserts.

First piloted in 11 schools (1984), HIP was expanded a year later to 38 elementary schools in the 29,500-pupil district.

Besides the Muscogee Health Project and the HIP program, this school district also carries out a special effort, K–6 drug education, called "Healthy Me—Drug Free," that integrates with other health education activities. District personnel are currently trying to integrate all health activities. "When we get it all together, we'll have a total health program," says Thornton. (For information, contact Carolyn Russell, Muscogee Health Project, 1532 Fifth Ave., Columbus, GA 31901.)

Van Buren, Arkansas:

"It costs money, but it's worth it. . . ."

School districts that want to adopt the School Health Curriculum Project (SHCP) or the middle-school portion of *Growing Healthy* may like almost everything about the program but its cost. In Van Buren, Arkansas, district administrators were lucky enough to get federal Title IV-C funds to pay for part of the curriculum.

Whatever the source of money, it's been worth the cost, according to Van Buren educators. Since the program has been put in place, teachers have noticed that school attendance improved among sixth graders. The curriculum has spread to several other grades. Students are scoring two full grade levels higher on standardized science tests than they did before SHCP was introduced.

Student enthusiasm for health runs high, too. Each spring, students help with the county hospital's health fair. They also put on plays and skits on health themes and carry out surveys of community smoking.

"Community and parental support has been tremendous," says Linda McDaniel, a teacher at Van Buren Middle School, pointing out that almost every local doctor and pharmacist has taken part in instruction. (The district now has a waiting list of professionals who want to help.)

The district started adopting the hands-on, discovery-oriented curriculum during fall 1980, when a Title IV-C grant paid for buying materials for 350 sixth graders and for training teachers. The next year, the curriculum was extended to the seventh grade, thanks to another Title IV-C grant and to a teacher training program at the University of Central Arkansas in Conway. The Van Buren schools sent teams—usually composed of a school principal, two classroom teachers, a school nurse, and a librarian/media director—to be trained at Conway, where they experimented with the same activities their students would later do in class.

By 1985, health education was reaching all fifth, sixth, and seventh graders in Van Buren. Fifth graders were learning about the human respiratory system and lung health, sixth graders were studying the circulatory system, and seventh graders were discovering how the nervous system works. Junior and senior high school students were getting still more health education through the Teenage Health Teaching Modules.

Cost is a serious problem for some districts that might like to adopt the SHCP but think the price of the materials is beyond their means. "The curriculum is very expensive to initiate. It also requires someone who is willing to give extra time to the program," says McDaniel, who is the unofficial district health education coordinator. In her district, for example, it costs more than $3,700 to equip one fourth grade classroom with support materials. Costs of materials for fifth and sixth grade classes come to more than $2,000 per room, and for a seventh grade class, to just over $5,000. "Textbooks would run another $500 or more," McDaniel continues, "and if the school does not have a good supply of audiovisual materials, it will face additional costs."

(For further information about the Van Buren program, contact Linda McDaniel, Van Buren Middle School, 913 North 24th St., Van Buren, AR 72956.)

Gresham, Oregon:

Wellness for staff administrators, and students, too

After staff members from two Gresham, Oregon, school districts attended the state department's Seaside Health Conference (see p. 57) during summer 1982, they came home determined to promote health in their schools. Teachers were ready to spread the word about healthful living to their colleagues, many of whom followed lifestyles that eventually would endanger their health. Administrators also were concerned because poor lifestyles were reducing job productivity and adding to the district's health costs.

Superintendent James Jenkins also became excited at the prospect of health promotion. "We ought to be heading

toward health promotion as a nation," he asserts. "I'd rather spend money on prevention than on cure."

Toward Better Teacher Health

The Gresham district program got underway in the fall of 1982. As a first step, its planners decided to make their colleagues more aware of lifestyle problems. All staff members of the Gresham Grade School District (seven elementary and two middle schools), were required to attend a half-day inservice in late September, where they learned about the general idea of wellness and about a new wellness course that the district intended to offer. The program was repeated at the two schools that make up the Gresham High School District. Oregon's state department health education specialist, Len Tritsch, addressed the meetings, which included "wellness lunches." After the meetings, 149 staff members (about one-fourth of the teaching staff) signed up for the 12-week-long course.

Course enrollees took pretests in physical fitness and mental well-being and completed nutritional and behavioral inventories. After the data had been processed, individual and group results were reported back to participants, who then set their own health goals and signed contracts promising to meet them. Those who enrolled also agreed to follow a regimen for eating presented in *Dietary Guidelines for Americans*, a U.S. Department of Agriculture-Health and Human Services publication, and to perform certain physical exercises for 20 minutes three times a week.

At the second meeting of the class, a physician explained to participants how to practice health self-management. Enrollees started their individual eight-week improvement programs the next day. Some schools chose to conduct regular exercise classes, held after school and not financed by the school district, but most participants were on their own in deciding how they would meet their exercise goals. Walking was the most popular exercise reported by the Gresham participants; running and jogging were second; aerobic exercises or aerobic dancing was the third popular activity.

Throughout the course, participants had to submit weekly reports of their health-related behavior. They also attended lectures on physical fitness, nutrition, stress management, harmful habits, and self-responsibility. Program directors reported that the pre- and post-testing and the weekly rundowns of health activities were the things that did the most to motivate the participants.

When the eight weeks were up, course participants were tested again to determine how the program affected them. Before the program started, five of the teachers had received "poor" ratings on the physical fitness tests, and 28 others were rated "low." Twenty-two were rated "good" and none "excellent." After the exercise, however, only one teacher kept the "poor" rating, 17 were still "low," while 37 had moved up to a "good" rating and three rated "excellent." Of the 12 teachers who showed indications of mental distress on tests before the program, only three remained in that category afterward. The number of staff members with positive ratings in mental well-being had grown from 40 to 73.

Now, About the Students

The wellness program also began to change what was happening in district classrooms. During 1983-84, elementary teachers began giving fitness tests to their students. New textbooks and instructional materials that focused on nutrition, physical exercise, and drug use also began to appear.

In September 1984, a freshman health promotion course was introduced at Sam Barlow High School (some elements of the course are used at Gresham High as well). The course combines health and physical education, and concentrates on four goals for students: physical fitness through exercise, good nutrition, stress management, and health appraisal for decision making. A team of eight teachers handles instruction. Students spend three periods a week in the gym working out and two others in class learning health concepts. "The idea is to teach health and then practice it through physical education," says Marsha Curtis, who writes curriculum for the program.

(For information, contact Wink Chilton at Gresham School District 4, 1333 Northwest Eastman Ave., Gresham, OR 97030.)

District of Columbia:

A program titled "Know Your Body"

Washington, D.C., school administrators look to a comprehensive curriculum to strengthen health education called *Know Your Body*. This resource seeks to influence students' attitudes and behavior toward drugs, alcohol, nutrition, and physical education at an early age.

Educators using this curriculum start off by screening children for medical problems such as high blood pressure, high cholesterol, and obesity. Children keep "health passports" that record their progress in correcting deficiencies. Results are reported to parents. One of the curriculum's major objectives is to get youngsters to monitor their own health in the future.

The physical education phase of *Know Your Own Body* is important—and expensive. Some 15 hours of training are required of physical education teachers, according to Paula Barry, director of health education services in the District of Columbia. The program also must be coordinated at the building level, a task usually performed by principals and physical education teachers.

Physical examinations constitute one of the curriculum's biggest expenses, especially for bloodwork, which can cost up to $10 per child. Student workbooks cost about $2-3 each, and a teacher's guide costs another $20. "It would be expensive for a school district to do this with only its own budget," says Barry.

Fortunately, Washington, D.C. has found an outside "angel" who pays for this health education program—teaching the curriculum has cost the school district nothing but teachers' time. Financial help comes from the National Institutes of Health, and other sources. (For more information, contact Paula Barry, Department of Health, District of Columbia Public Schools, 12th and D Streets NE, Washington, D.C. 20002.)

Wiscasset, Maine:

"With the community's support and approval . . . ."

When educators in Wiscasset, Maine, began wondering whether their district and the students would benefit from a comprehensive health education curriculum, they decided first to see how the community felt about the idea. School officials decided that a needs assessment would be a good way to measure community attitudes toward various aspects of health education. With assistance from the state education department, they designed a form that students took home to their parents. Forms were also distributed through stores and shops.

The assessment forms listed ten topics that the educators felt were important for comprehensive health education—community health, consumer health, environmental health, personal health, nutritional health, family life and human sexuality, growth and development, disease prevention and control, safety and accident prevention, and substance use and abuse. Listed also were subtopics. Appearing beneath *Community Health*, for example, were the subtopics

- Individual responsibility
- Healthful school, home, community environment
- Occupational environment
- Safety hazards and natural disasters
- Health service careers
- Community involvement.

Subtopics for *Growth and Development* were

- Ages and stages—birth to death
- Understanding death and dying
- Aging
- Body systems and functions.

Parents and other local residents were asked to indicate at what grade level they thought each of the 60 subtopics should be taught (primary grades, middle school, junior high, or high school), or whether they believed the subject belonged in the schools at all.

Authors of the survey form took care that the assessment form did not rouse community fears about possible curriculum changes. "Remember, even though a particular topic is mentioned in the survey," the form states, "that does not necessarily indicate that the topic in question is a current practice or that it will be a future practice."

To probe community views about health education further, the form asked respondents to rank ten topics in order of importance and asked questions aimed at gauging how much overall support for a program existed. (Would respondents be willling to attend a meeting to discuss health education? Would they support the hiring of a health teacher or health coordinator?)

When the responses were analyzed, educators in the rural Maine community learned that the majority of those who returned the questionnaire would support hiring a health coordinator. Says Andrew McAuliff, the district's director of special services, "The needs assessment gave us parameters—that's the best way to put it—as to what the community is looking for." From the 1,200 or more assessment forms distributed, the district got back about 150. "That was a greater response than we anticipated," says McAuliff.

Information from the needs assessment will be used as one part of this district's overall curriculum review program. Superintendent Randall Collins has launched a five-year review program to monitor and update the content for each subject taught in the schools, and he has decided that health/physical education should be one of the first to be studied. (Further information from Andrew McAuliff, Special Services Department, P.O. Box J, Wiscasset, ME 04578.)

Lansing, Michigan:

And this is what they did in only one year

Lansing, Michigan, educators have demonstrated how much a district can accomplish in one year when it comes to putting a health education curriculum into action. Using the state's comprehensive kindergarten through grade-eight curriculum as a model, the district started to work during 1984. By spring, district staff had organized a community planning and advisory committee, produced a curriculum implementation plan, collected the materials to teach it, and trained teachers.

Under Michigan's state plan, local district participation is voluntary, and in Lansing, this principle applies to the school buildings as well. After the comprehensive curriculum idea won the support of Lansing's superintendent, Robert Chamberlain, the district health coordinators presented an

implementation plan to the principals. Interested principals were then invited to present the plan to school building faculty, who were free to decide whether or not to take part.

Thirty-two teachers in the 24,000-pupil district were interested. "Health education has a loyal following," says Helen Truchan, a health coordinator. "People who want to teach health are delighted to have the materials to do it." Plans call for training eight teachers at each participating school every year.

The Michigan state model curriculum consists of a core of 40 to 50 lessons, lasting about 20–30 minutes each, which are to be taught for a semester at each grade level. While all participating teachers must teach this core, the program is flexible enough for teachers to add or modify elements as they see fit.

Hands-on activities—worksheets, filmstrips, materials that teachers prepare in training workshops and then take back to their classrooms—make up most of the lessons. Second graders, for example, learn from models of the ear and the eye; and one activity calls for them to dissect the model eye. Third graders use dog food "bones," paper clips, sponges, and rubber bands to make models of the human spine, and demonstrate how the spinal column, composed of vertebrae and discs, can be both strong and bendable. In another class activity, children toss about a ball of yarn, and the teacher explains that this is the way germs travel through the air, passing from person to person by touch or by sneezing. Teaching materials are kept at classroom learning stations, called "hunting grounds" for fourth, fifth, and sixth graders.

Teachers are trained for the health education work in a series of workshops spaced throughout the year. Training is provided through intermediate-level health coordinators, who are paid by the state.

Money to implement all health programs comes from the state department of education and from six other state agencies with an interest in preventive health and safety. Funds are channeled to local districts through intermediate-level educational service agencies. Each district must come up with at least 20 percent of its budget in matching funds.

Like other participating districts in the state, Lansing organized a local advisory committee, including representatives of the local health department, local and state dental associations, and the American Automobile Association, with its interest in accident prevention. The advisory committee helps raise the matching funds required from the district. Community resource people have taken part in class instruction—among them, a radiologist from a local hospital and college students from an area institution who assist with dissections.

Lansing school officials concede that the district hasn't drawn on local resources as much as it could, and plans to do more of this in the future. (For information, contact Helen Truchan, Lansing Public Schools, 519 West Kalamazoo St., Lansing, MI 48910.)

Northern New Jersey:

They took the public's advice seriously

New Jersey school administrators and their curriculum staffs have been busy fulfilling a state mandate requiring teaching family life education. State guidelines appeared in 1981. By 1983, the Northern Valley Regional High School in the suburban northeastern part of the state had a new curriculum in place for family life instruction and health education and had accomplished the tasks without much controversy.

According to Edward Ciccoricco, director of curriculum for the regional district, the careful and deliberate cooperation between the school district and its public helped smooth the way for the new curriculum. Under New Jersey law, family life education curricula and materials must go through an extensive review process—for the Northern Valley Regional High School this involved working with seven North Bergen County towns that make up the regional district.

To start the process, a health education curriculum committee—four school nurse/health teachers, five physical education/health teachers, two physical education department supervisors, one school nurse, and Ciccoricco—was established. By early 1981, this group succeeded in developing objectives for family life education.

In that same year, the district hired an outside consultant, (a professor of education at Kean College, Union, New Jersey) to outline content for teaching the objectives. After the curriculum committee reviewed the consultant's recommendations for content, the list of objectives and materials for the program was submitted to a regional-level community advisory committee. This group suggested changes and then endorsed the program unanimously.

Regional superintendent John J. Howarth and his counterparts in the towns that belong to the regional district had recommended members for the committee—persons they knew would be able and willing to help. Students had something to say about the new curriculum, too. "Students were included," says Ciccoricco, "because they said they needed this information, and we felt it was better for them to get it from authoritative sources rather than from sources not well-informed, such as their peers."

Suggestions from the community advisory group were taken seriously by school authorities. Ciccoricco feels that allowing all members to express their views helped establish confidence. "Because of full participation of staff and community in recommending changes and reviewing them, and because we respected religious points of view—all these factors helped diffuse anxiety," he says.

The curriculum review process still wasn't over, however. The revised guide had to be approved by organizations representing instructional specialists, principals, and ad-

ministrators from all participating local districts. Then the package went to the board of education in each town. By March, all the school boards had acted on the new curriculum, which went into effect during fall 1983.

The curriculum that emerged from this process covers family relationships, family responsibilities, human development, child abuse, influence of heredity and environment, the reproductive system, peer pressure, childbirth, and sexually transmitted diseases. One sensitive topic, birth control methods, is put off until high school, when students must take a quarter of health education every year.

Students can be excused from the family life program if they or their parents have religious or moral objections. That so few such requests have been made indicates that the program is well-received, according to school administrators. (For information write to Edward Ciccoricco at Northern Valley Regional High School, 162 Knickerbocker Road, Box 270, Demarest, NJ 07627.)

Fairfax County, Virginia:

They did something—a lot—about teenage suicide

Fairfax County, Virginia, public schools are trying to do something about the alarming rate of suicide among teenagers. An effort by the district's department of student services enlists administrators, teachers, parents, and students to stop adolescent suicide. Since the program started three years ago, the teenage suicide rate in the county has dropped.

The adolescent suicide prevention program began in 1982, with school social workers, psychologists, and counselors playing a role alongside teachers and administrators. Health education classes are used as an important means for exposing students to suicide prevention information.

Teachers attend inservice training to recognize signs of depression that may indicate that one of their students is a potential suicide victim. They also become familiar with basic suicide prevention measures. A film, *Adolescent Suicide: A Matter of Life and Death*, and mental health specialists are used for inservice activities.

Parents are crucial in the suicide prevention program, and meetings for them have been held in county libraries, community centers, and schools. Like inservice sessions, the meetings usually follow a film-and-discussion format. Presentations have been given at parent-teacher meetings and at meetings of single parents, because studies indicate that children of divorced parents are especially at risk.

Students themselves hear speakers on suicide and depression at student assemblies and learn more about the suicide danger in health education classes. (Among other things, speakers have tried to discredit "some of the common adolescent fantasies about death," according to a description of the district's program.) Principals have encouraged students to start groups in which they can discuss the suicide problem with their peers. Student discussions emphasize ways to recognize friends who need help, and the importance of calling on responsible adults if a friend has a problem.

This program also has made use of the school newspaper to get the word to students about suicide risks and problems. In one activity, mental health professionals give interviews on suicide prevention to student reporters. Student newspaper articles have been effective in increasing students' awareness. (For information, contact Myra Herbert, Department of Student Services and Special Education, Belle Willard Administrative Center, 10310 Layton Hall Dr., Fairfax, VA 22030.)

New York City, District 24:

Why a big city likes a comprehensive health program

To say that Anthony Sanfilippo believes in health education is to understate the matter. "I don't care how smart you are or how much you achieve, unless you have good health, you can't enjoy life," says Sanfilippo, superintendent of New York City Community School District #24. "The schools have a responsibility to provide for the health and safety of children. That's just as important as the three R's."

Sanfilippo also thinks that the School Health Curriculum Project (now part of *Growing Healthy*) is the best one on the market for a district like his. "It's comprehensive and it's not too controversial," he explains. "It's here to stay."

Big-city educators like this curriculum, with its emphasis on nipping bad health habits—cigarette smoking, drug and alcohol abuse, poor nutrition, and poor physical fitness—in the bud. In some New York City classrooms, teachers use *Growing Healthy* to impress on students the importance of regular medical care and dental checkups. Some teachers conduct visits to grocery stores, dairies, or canning factories to show students that there are many tasty alternatives to junk food. New York City teachers try to reach parents, too. After outreach workshops, some parents help reinforce lessons in safety and good health at home and place good medical and dental care on their own agendas at home.

Anthony Sanfilippo's district was among the first in New York to take advantage of an offer from the New York Academy of Medicine to help city schools bring the School Health Curriculum Project into classrooms. In the late 1970s, the academy began looking for a health education program it could recommend for city schools. Its first choice was the School Health Curriculum Project (SHCP), and the academy began offering grants and opportunities for teacher training to school systems that would match the money with their own funds.

Community School District #24 took up this offer about six years ago. The academy agreed to provide $1,500 for start-up materials, teacher training, and on-site supervision, while the school district promised to invest a like sum in the health education program. That first year, teachers from four schools in the district took part in summer workshops, along with colleagues from other New York schools. The district and the Academy pursued this arrangement for several years. Gradually, more teachers were trained and more materials accumulated.

District #24's long-range goals are to have one complete set of *Growing Healthy* materials for each grade level in its 19 elementary schools and to train all elementary school teachers. "The success of this program is predicated on intensive teacher training—three to six full days," says Edward Clark, an assistant to Sanfilippo, who oversees the district's health curriculum. "How do you get all the teachers trained? You're talking large numbers here." Clark has been looking for outside money to pay District #24's training bill.

Clark's responsibilities for the program consist largely of scheduling training, liaison with the board of education and the Academy, and distributing materials—a big chore. One of his ideas was putting all the project films in a central district library, thus improving access to some of the most expensive project materials. (For information, contact Anthony Sanfilippo at Community School District #24, 67-54 80th St., Middle Village, NY 11379.)

Eagle Point, Oregon:

Changing attitudes for healthful living

How do you change students' behavior so that they follow healthful lifestyles? First, you have to change their attitudes, according to Dennis Gerke, who teaches health education at Eagle Point, Oregon, high school. "If a belief or an attitude is changed," says Gerke, "a hundred behaviors will be changed."

Gerke has devised a number of methods for changing the health habits of students in his Health Skills for Life course. In one effort, for example, he concentrates on helping students see the immediate impact that harmful substances have on their bodies, a strategy that works far better, he says, than warning them about what will happen to their health 30 or 40 years later. At the start of this unit, students keep a journal for two weeks, describing what they have eaten, drunk, smoked, or chewed. Then, as a culminating activity, Gerke lets them eat, drink sodas, or smoke in class for one day, while biofeedback machines furnished by the Oregon Lung Association and the American Heart Association monitor how their bodies respond. A student who eats a bag of chocolate chips, for example, can watch his pulse and blood pressure rise while his skin temperature drops and a tremor in his hand becomes pronounced.

Another of Gerke's strategies involves grading. Instead of giving students grades based on tests, he asks each of them to write a "growth skills summary" each week that explains how they have *used* what they have learned in class. Each student then gives himself or herself a grade based on a personal view of how valuable it has been to learn a particular skill. Finally, Gerke and the student arrive at a grade for the week's work. Here are comments these students wrote in their summaries after lessons on listening skills and stress management (1984-84):

"This week I grew in being able to talk about things that hurt. When my Dad left, I was very bitter for a long time, over money and things. But I learned to express myself, and I was able to tell the class about my experience when Dad left."

"This past week one of my friends betrayed my trust. But instead of fighting about it, I confronted him and asked him why. When he told me why, I agreed with him."

"This week Mr. Simpson gave me some extra-credit typing. Monday through Tuesday my head, shoulders, and especially my neck killed me, but when I went home I was able to completely relax. I'm not sure if that is growth but to me it is."

(For more information, write to Dennis Gerke, Eagle Point High School, P.O. Box 198, Eagle Point, OR 97524.

Chapter 8

Health Services

The school nurse is foremost in providing health services for students and staff — What the school nurse does and should do — Interview with a school nurse

A district's health services constitute one of the three elements of a comprehensive school health education program—along with health instruction and a proper environment. Few districts have school physicians or other specialized personnel such as psychologists and psychiatrists. For most, health services means the school nurse. In many of these districts, school nurses or other health service personnel do little more than manage the sick room. They can do much more: a school nurse can become a partner on the health education team, offering expertise that contributes to students' long-term health.

Much of the time, health service staff members are busy meeting students' present health needs: they see that communicable diseases, including head lice, are kept under control; they screen students not already screened for developmental defects that might interfere with school work. They keep health assessment and immunization records up-to-date and review the information periodically to ensure that students get booster shots on time.

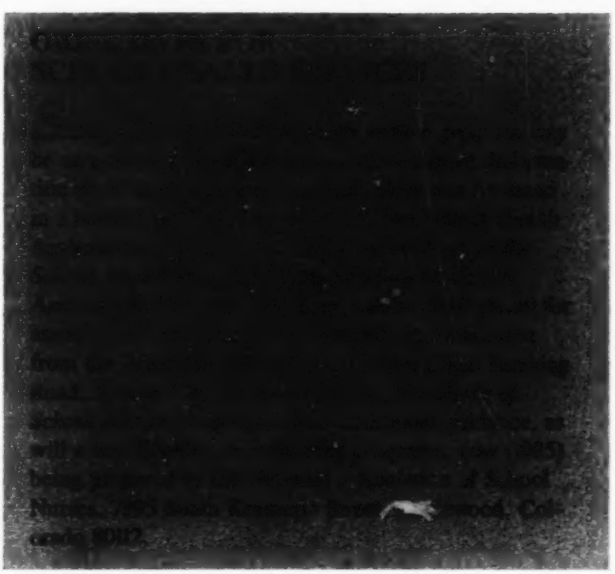
Going beyond routine nursing duties, health service staff can take part in curriculum development and inservice teacher training, providing information about health problems and solutions. They can also help teachers watch for some of the subtle indications that a student has health-related problems—persistent inattention, lack of energy, depression, or signs of child abuse. And they can get teachers interested in basic health concepts, such as fitness and stress management.

Helping Students Learn

Health service staff can also help students learn about good health by turning routine visits to the sick room into counseling and teaching sessions. Contacts with students' families can be used for the same purpose, as nurses encourage parents to seek regular medical and dental care for their children and warn them not to neglect immunizations for younger children. Their role in special education is also important. A school nurse may know enough about a student's disability and any consequent learning problems to help teachers draw up an appropriate individual education plan. School health service staff can even help improve parent/school relations by listening to anxious parents' inquiries and answering their questions.

Investing in Health Services

Administrators responding to the AASA survey reported that a strong health service component pays off—improving both students' health and their learning. To keep this phase strong, administrators often draw up goals and objectives for health services, just as they define objectives for other educational programs. Like other educational objectives, health service goals are set with local needs in mind. Schools with many handicapped youngsters will have extra demands of health service staff. Schools with a highly mobile student clientele also see unusual demands for health services. The community's economic status makes a difference, too—poor families are not able to give their youngsters basic medical and dental care and turn to the school for help.



Setting Goals

Setting health service goals can help a district's program in two ways: the process lays the groundwork for coordinating health services and health education, and it furnishes reasons to justify investing in overall improvement of a school system's health program.

As administrators think through the relationship between health services and health instruction, they are likely to see that the health service program does indeed contribute to a district's overall educational mission. They may need to stress this fact when they talk with parents and community leaders. Many taxpayers have a vague idea of what school health services are supposed to accomplish. Ian Newman, in an article for the *Journal of School Health*, October 1982, said: "Without clearly stated goals and objectives for health services and education programs, there is neither a basis for [program] integration nor a basis on which to appeal for community support."

Delivering the Program

Health service program objectives depend, however, to a great degree on a district's resources, and not even the most supportive administrator can always convince the board to hire adequate health service staff for every school.

Ideally, a school should have at least one nurse for every 750 students, according to a resolution of the National Association of School Nurses. Schools with mainstreamed students need more nurses—*Standards of Nursing Practice* recommends a nurse for every 225 students.

These goals are not uniformly met. Even state standards do not hold to this student-nurse ratio. Colorado, for example, calls for a nurse for every 1,300 students.

Time for Nurses: If a nurse is responsible for too many students, some of the most important work may not get done; the aims of state mandates may be frustrated even though the letter of the law is obeyed. "If you have a screening program because the state requires it, and you just screen students and put the information on a card and file it until the next screening, that's not helping the student," warns Dana Davis of the American School Health Association. "Nurses have to have enough time to talk to parents and tell them how to follow up on their children's health.

Making referrals is an important aspect of a school nurse's job; it is also one of the areas most apt to be neglected. "If one nurse is responsible for 2,000 or 3,000 children," Davis continues, "and finds that five of them need corrective lenses, she may not be able to keep track of them well enough to make sure these children get the glasses they need. The problem is especially acute if the nurse is not at the same building every day."

Overloaded nurses may not have time to keep up contacts with community agencies, which often help deliver the services to meet children's health needs. This problem can be especially serious for schools with many disadvantaged pupils who lack medical insurance or access to routine medical care.

Sharing Nurses: Some schools manage to share nurses successfully. Whether sharing works depends on how many children must be served at all the schools, how far the nurse must travel from one school to another, and to homes of parents. One Oregon district provides screening, immunization, and educational services for students and training for other school staff members (including certification in cardiopulmonary resuscitation and first aid instruction) with three part-time nurses.

Who Trains Nurses

The qualifications of the nurses who fill school health services posts vary widely from district to district and state to state. Nurses can be trained in two- or four-year hospital-based programs; or they can be college graduates who hold baccalaureate degrees. Some college graduates have teaching as well as nursing credentials; others do not.

The best arrangement, most experts say, is to employ a nurse with a baccalaureate who can also step into the classroom and teach. In the Bronx, New York, for example, nurses teach in conjunction with screening programs. They explain anatomy and physiology and tell children about the health problems that screening is supposed to detect. In other districts, school nurses are showing children how to perform basic medical tasks, such as measuring blood pressure, and encouraging them to take responsibility for their own health.

College graduates often are better prepared to work with the community than nurses who get their training in hospitals or clinics. College-trained nurses usually have less trouble winning the respect of teachers. This factor can be important if nurses are to become valued members of a health education team.

School Nurse Practitioners and Aides

Some school systems, particularly doctor-short inner-city and rural districts, are discovering a boon in school nurse practitioners (SNPs), school-based nurses with special professional training. SNPs are licensed by some states to dispense

certain types of medication and to diagnose minor ailments. They generally keep in contact with physicians who treat children's more serious medical problems.

On the average, SNPs cost districts about $43 to $82 per child per year. A recent evaluation of school nurse practitioner programs in 18 districts in Colorado, New York, North Dakota, and Utah demonstrated that these specially trained nurses can be effective. "Time and time again, in routine screening or sports physicals, we'd pick up problems that had never been identified and that no one had followed," says Kathleen Stillion-Allen, school health consultant at the Utah Department of Health. Ailments the SNPs discovered included cardiac arrhythmias and orthopedic problems. Immunization rates roughly doubled at some high schools as a result of the SNPs.

Districts where a full-time nurse seems a luxury sometimes find a partial answer to their needs by hiring health aides, who mind the school sickroom on a full-time basis under supervision of a part-time professional nurse. Researchers who observed this kind of arrangement at a (1,200 pupils) rural elementary school concluded that the aide was able to meet a high percentage of the children's basic health needs—dispensing medicine (on doctor or parental orders), and screening for vision, hearing, and height/weight problems—at a cost of about $43 a day, or $1.89 per student/aide contact. The aide also answered parents' questions about health topics and immunizations and, in some cases, arranged for referrals.

Although such an arrangement has its shortcomings, a health aide is better than no health service staff at all. Besides basic first aid, health aides also can perform such tasks as arranging transportation home for sick children. Those who observed the health aide program calculated that without the aide, tending to routine problems would have taken up one-half of one teacher's time over the year.

What a Good Program Can Do

Currently districts are, for the most part, not expanding or even maintaining their health services components. Health services tends to be one of the first areas to be cut as school budgets grow tighter. The cuts may be particularly unfortunate now, because recent developments in the health service field indicate that the following basic services are all but imperative:

Health Assessment: In addition to offering the usual hearing and vision tests, health service staff are required to screen for scoliosis (curvature of the spine, a correctable condition that often goes undetected in adolescent girls), nutrition problems and obesity, sickle cell anemia, tuberculosis, and high blood pressure.

Some school districts also do health-risk appraisals that warn youngsters about how their bad health habits can shorten their lives. A Providence, Rhode Island, school program features an Apple II computer that travels to junior and senior high schools in a van. Students at each school fill out risk-appraisal questionnaires, and the computer prints out their scores, along with advice about how to reduce the particular risks that endanger them.

Dealing with Emergencies: Since many schools do not have a nurse on duty throughout the day, some administrators set up committees to draw guidelines that inform teachers and other staff how to cope with emergencies. Saginaw, Michigan, health coordinator Pari Michalski put together a manual containing all districtwide health policies, lines of program responsibility, samples of form letters to parents on different topics, and materials on other health concerns. Pertinent sections of state laws are included.

Some districts find that it pays to keep such emergency care manuals within easy reach of teachers. The manuals usually spell out where emergency supplies are kept, when to call the rescue squad, and how to make arrangements for getting sick youngsters home. They may also designate the people at each school as emergency care providers. Many districts train staff members in emergency techniques such as cardiopulmonary resuscitation and the Heimlich Maneuver (to dislodge objects caught in breathing passages). Procedures for getting medical release permission from parents may also be outlined, along with what to do when staff without special medical training must act in an emergency.

Recordkeeping: Keeping accurate records on student immunizations and other health topics is a time-consuming but necessary health service. Problems usually arise when children move. Their records may not follow them to the new school, or the old record format may be incompatible with the new school's system. The Office of Disease Prevention and Health Promotion is encouraging development of a standardized health record form that might be used across the U.S. The National Association of State School Nurse Consultants is developing such a form (1985). Administrators interested in following developments in this area may contact the Office of Disease Prevention and Health Promotion in the U.S. Department of Health and Human Services, Washington, D.C.

Interview:

A School Nurse Speaks Out

Sylvia Averell wears three hats to carry out her responsibilities with the Richmond, Maine, public schools (600 students). She is the district's health coordinator, school nurse, and she teaches. Recently, she also led the team that designed a new district health education program. Here, she talks about her job and tells what administrators could do to make it more effective.

Q: What does a school nurse typically do?

Averell: There are as many different job descriptions as there are nurses, because the job varies, depending on school size and type of community. Your larger schools may try to cover 2,000 to 3,000 students with one nurse. Ideally, there should be far fewer students per nurse, but not many districts meet the ideal. In fact, in most districts, nurses often do a lot of things besides school nursing. Most of us also take on special projects.

Q: What kind of projects?

Averell: Well, fluoridation was one of the big health objectives for the schools defined by the U.S. Public Health Service. The feds make grants to schools, paying for educational materials about fluoridation and for fluoride pills and rinses.

Q: What do you do to carry out this program?

Averell: I am project director here in Richmond, and that means that I write up the grant proposal, do the paperwork, and order supplies. There are weekly fluoride rinses for students. I have to have parental permission, so there's a lot of paperwork involved. I also do hearing, vision, and scoliosis screening.

Q: What about immunization?

Averell: State law now requires a child to have immunization before entering kindergarten. With that law, the need for immunization at school decreases, but the paperwork increases. Records being transferred between schools are a big problem. Nurses spend hours trying to track them down.

Q: Some schools get their nurses from the county health service. Is this a good arrangement?

Averell: Usually these are public health nurses, and they are very good. The problem is that they spend so little time in the system that there are a lot of things they simply can't do. They're just not in the schools the number of hours that a school nurse should be. One of the common misunderstandings is that if you don't have a nurse at every school all the time—that the school secretary can take care of minor things, while the nurse only gets involved in the bigger health problems. That's wrong.

Q: What happens if a school district does not emphasize school nursing?

Averell: Then you have a lot of health problems that go unnoticed for a long time. If you detect the lazy eye in kindergarten, it can prevent blindness in that eye. If it's not detected early, a child can lose his or her sight.

Q: What kind of instructional work do you do?

Averell: I prepare educational units on sex education for fifth and sixth grades. I also co-teach a coronary pulmonary resuscitation course with another teacher for high school students.

Q: And as health coordinator? What do you do?

Averell: To keep our health education curriculum on course, someone has to watch out that health objectives are taught, and that the teaching assignments in health do not overlap. I see that as one of the coordinator's tasks. I also supply teachers with the materials for the curriculum and pass on any new things that I hear about. I provide backup.

Q: How much do you spend on health instructional materials?

Averell: Now that we don't have state funds, we spend very little. We beg and borrow—mostly. The films we use are generally borrowed from a nearby university or from wherever else we can find what we want.

Q: Can you get a good assortment of things?

Averell: Yes, you can, usually.

Q: What else does your job entail?

Averell: I get child abuse reports and track them down. I do some counseling. I do a lot of listening, about emotional as well as physical health problems. Sometimes a student just needs someone to talk to.

Q: What should a school nurse expect from the administrators?

Averell: They should support health education and preventive measures, especially when some programs are controversial, like fluoride or sex education. But if the administration sees to it that sex education, to take one example, becomes a planned part of the curriculum, kindergarten through 12, there is much less likely to be controversy. I also think that administrators should respect the nurse. Here my principals are very supportive. They respect my ideas and they help share them with others.

Q: Could you give an example?

Averell: Well, going back to sex education, suppose you have a principal or superintendent who doesn't believe that it is important and is not willing to back you—then if you get complaints about the program, you'll really be up the creek. Naturally, as a nurse you won't get involved in a lot of important things if you know you're not going to get support from your administration.

Chapter 9

Parents

Parental involvement in health education makes the difference—School and home are natural partners for the promotion of children's health—Parents, too, get the benefit of good school health programs

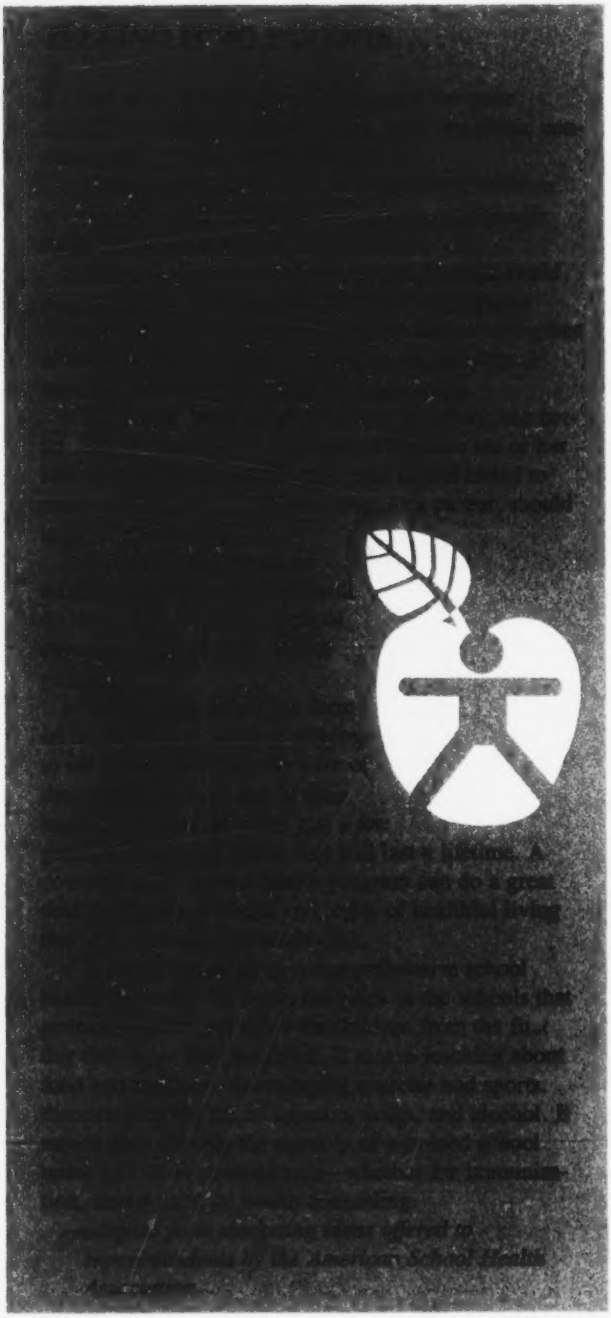
Involving parents is a particularly appropriate goal for school health education. When it comes to health, parents and the schools are natural partners. The health lessons that students learn in class should complement and reinforce home attitudes and practices. Problems arise if parents and teachers do not share similar health values. If this should happen, the two groups will inevitably end up working at cross purposes.

Giving parents a voice in program planning via a community advisory group is one way to promote parental involvement. Some districts go further to involve parents, inviting them to sit in on inservice training sessions for teachers when a new health curriculum is considered for adoption. Some school systems also open staff wellness programs to parents. This latter approach was used recently at the Bernardsville, New Jersey, school district, which offered a weight-reduction program in cooperation with a local hospital. Each participating parent or other family member paid $165 for the program, while school employees paid $65 each.

Other districts go out of their way to recruit parents for classroom volunteer duty, assuming that parents will become better informed about health education themselves and may turn out to be health advocates. Schools participating in the Appalachian School Health Education Program have made special efforts to sign up parent volunteers, because their program depends heavily on learning stations. While parents work at the stations, setting up filmstrips and handing out printed materials, teachers have more freedom for individualized instruction.

A paper titled "Acquiring Community Resources: A Reference for Teachers and Principals," offers tips on ways to recruit and use parent volunteers. "Parents can serve as guest lecturers, conduct small-group discussions, [assist] with various experiments, build needed equipment, and photograph events for slide tapes. Parents are a valuable resource—use them!" counsels the paper, available from the Regional Educational Service Agency of Appalachian Maryland, 153 Baltimore St., Cumberland, MD 21502.

Recognizing that parents are potent influences for instilling



good—or bad—health values, some school districts reach out to shape parents' views through parent education activities. Evaluators of many health education programs have discovered that health education does carry over. Parents are apt to try to quit smoking, for example, while their children are learning about the effects of tobacco. A heart health curriculum used in the Chicago, Illinois, schools resulted in another beneficial effect: Parents of children taking the curriculum were eating more nutritious foods and exercising more actively.

Workshops for Parents

School districts sometimes turn to more direct means for reaching parents. Workshops for parents are available on request to New York City school districts that take part in the New York Academy of Medicine-sponsored health curriculum project. The workshops help instill good health values and encourage parents to make sure their youngsters get regular medical and dental care. School districts often urge parents to take advantage of adult education courses, offered by county health departments, on smoking, drug abuse and alcohol education, or managing stress and family problems.

Letters to Parents

In Woodburn, Oregon, teacher Linda Durkos sends letters to all parents of her first graders explaining how nutrition, general well-being, and sufficient sleep can affect the children's learning. "It is extremely important that your child get an adequate amount of sleep," states one of her letters. "The needs of each child vary, so does the amount of sleep he or she requires, but a good suggestion is to put your children to bed early, let them awaken naturally, and observe if they do not tire during the day." The letter goes on to warn that too much junk food or sugar can pose both emotional and physical problems for many children.

Help from Parent Groups

The local parent-teacher association offers another route for parental involvement in health education. Both the National PTA and several state-level organizations have been active promoters of comprehensive school health education. During the late 1970s, the National PTA launched a Comprehensive School/Community Health Education Project that created pilot programs in 13 states bent on helping communities understand health education and gathering support for better health. One outgrowth of this venture is a manual to help PTA leaders plan similar programs. Contact either your state PTA or the National PTA, 700 North Rush St., Chicago, IL 60611, for information about this project.

From another source comes a pamphlet, *What Every Parent Should Know About Health Education*. It is published by the Association for the Advancement of Health Education, Reston, Virginia, and offers tips like these:

- Find out whether the school offers a comprehensive health education program and, if so, ask how you can help
- Take an interest in what children are learning, and check on any health problems that might relate to the family
- Provide examples that value health
- Practice home safety, especially regarding toys, drugs, and cleaning agents.

Chapter 10

Wellness

Staff wellness, staff well-being, staff health: all are an integral part of health education—Changing and improving behavior of teachers and other staff members—An interview with an authority on staff wellness

Some teachers smoke. Some eat junk food. Still others show through their personal behavior they do not respect measures of ordinary safety.

Such teachers—and other school employees with similar habits—serve neither their own interests of wellness nor those of the students around them.

It is for this reason that school districts are beginning to put effort into changing the behavior of school staff members. Health education is one area where it is all-important that what we preach and what we practice are in harmony.

Wellness for School Staff

A few districts have taken steps to make it possible for administrators, teachers, and other school staff to take part in staff development programs that focus on nutrition, exercise, stress reduction, and safety awareness. The hope is that if staff members learn what healthy behavior is and practice it, they will provide role models that will help motivate students toward healthy behavior.

Staff wellness programs are relatively new phenomena. Most began as recently as five years ago. In part, these programs are modeled on those in private industry, where they often brought about lower insurance costs for companies and better health and morale for employees. School administrators who have tried this approach believe that the program results in better health education for students, too. Teachers are more enthusiastic and have more energy, and their enthusiasm makes health instruction more interesting for students.

"Unless people are interested in their own health, they're probably not going to be very interested in anybody else's," says Len Tritsch, Oregon Department of Education consultant in health education. "Health hasn't been very exciting because the teachers weren't excited about it."

School staff wellness has been one of Tritsch's top priorities since 1977, and his effort has paid off in terms of better school health instruction in Oregon.

He and other advocates of this approach argue that it pays off in other ways as well—for example, by letting teachers know that the district cares about their health. In addition, advocates say, it saves money. A healthy staff means fewer substitute teachers and sometimes lower insurance rates.

Oregon's Seaside Conferences

Oregon's chief instrument for making teachers and administrators health-conscious, under Tritsch's leadership, is a week-long conference, held every year since 1977, in the coastal town of Seaside, in northwestern Oregon.

School employees go to Seaside in teams. Each team must have a teacher and an administrator but may also include board members, parents, school nurses, and cafeteria personnel. The team approach helps guarantee that when the members go back to the district and try to be agents for change, they'll be able to give one another support.

At the Seaside conferences, team members select a specific health area for improvement—for example, becoming more fit, eating more nutritious foods, or reducing cigarette smoking or alcohol consumption. Classes or seminars on more than 100 topics are available to the several hundred participants who attend the annual conferences. Each signs a contract, pledging to correct at least one element in his or her lifestyle.

Things Happen

Among the Oregon school districts that have sent teams to Seaside has been Gresham. (See the case study on page 45.)

And as Gresham's staff has done, educators from other parts of Oregon who have attended the Seaside conferences have translated their experiences into changes at their home schools. For example: Teachers who have attended Seaside have incorporated more health themes in their teaching. Food service personnel have become more nutrition conscious, and curriculum workers have enhanced and enlarged the scope and sequence of health offerings. Aerobics classes had sprung up at many schools, and more health fairs were being held than ever before.

Seaside has also had a lasting effect on participants' lifestyles, according to researchers who investigated its effects. One vice principal who had been smoking for 13 years credited the conference for giving him the resolve to quit.

Many teachers were running or doing other forms of exercise on a regular basis. One high school principal discovered that he had high blood pressure as a result of a health appraisal at Seaside. He consequently shed 30 of the 60 pounds he wished to lose through exercise and dieting.

Saving Money

With or without Seaside-type programs, health promotion for staff can save money. One administrator has reported that his district's staff wellness plan has saved money because his schools have had to hire fewer substitutes. "I can say from 20 years' experience that I've had fewer teachers absent due to illness than in the past, and much of this record is due to their inservice on stress management, diet, alcohol and tobacco, and general staff fitness."

One Oregon school district, Josephine County, saw health insurance premiums drop sharply as a result of staff health promotion. Insurance company officials estimate that the district saved as much as $336,000, based on trends of the past several years. The district is covered by a locally owned firm that has worked with Josephine County schools for many years. The company initiated the health promotion proposal and is trying to market the concept to other school districts. "When the insurance people approached us with the idea, we jumped at the chance," says Kathy Krouse, district business manager. Josephine County teachers get a rebate on their own insurance premiums if they keep health costs down.

Health Promotion in Dallas

Officials at the Dallas, Texas, Independent School District say that a staff health promotion program has saved money there, too. A comparison of attendance records of 3,700 teachers who participated in a fitness-health promotion program sponsored by the district with nonparticipants' records showed that participating teachers used about three fewer days of sick leave over the year than the others. That resulted in a savings of about $452,000 in substitute pay. District officials also think they saved money on health insurance but are not sure just how much. The school system has changed insurance companies twice since the health promotion program began and is now self-insured (except for cases that cost more than $100,000).

Like many staff wellness programs, the one in Dallas emphasizes exercise, nutrition, and stress management. Participants undergo medical tests, receive appraisals of their health and fitness status, set goals, and start individually prescribed programs that emphasize health information and exercise. About 4,000 school employees participated in 1982, the program's first year. By 1984, about 7,000 staff members had taken part. Each employee pays $125 for a year's participation, and the district pays the rest.

Superintendent Linus Wright endorsed the program from the start and became an enthusiastic participant. A superintendent's life consists of too many breakfast and luncheon meetings and too many long hours, all of which work against a healthful lifestyle, Wright said recently, when he started running every morning. "If we are going to ask our teachers and staff to improve their fitness as a way of reducing stress in their jobs, then I had better set a good example," he added.

A Dallas-based organization called the Institute for Aerobics Research conducts the program under contract with the school district. The institute provides instructors and materials, while the school district furnishes facilities and much of the testing and exercise equipment. In 1985–86 the Dallas schools were expected to spend about $465,000 for the district's share of the cost. For this outlay, Dallas school officials say, they get teachers with more energy and higher productivity, fewer substitutes, and better staff morale in general. "The morale factor is so high with participants that it *has* to have a real effect on the learning process," says Wright.

Other Types of Programs

Local hospitals can assist also in school staff health promotion programs. Several Iowa school districts are working with Iowa Lutheran Hospital in Des Moines to incorporate a health promotion program run by hospital staff and carried out in local schools. In Greenville, South Carolina, St. Francis Community Hospital offers a two-week summer session for teachers, who learn how to protect their own health and promote health among students. Among other things, the hospital provides teachers with educational materials on all health topics taught in South Carolina schools.

Districts interested in starting their own health promotion programs can find tips on how to do it in a new manual, *Wellness at the School Worksite*, published by the Health Insurance Association of America and the American Council of Life Insurance in cooperation with the Association for the Advancement of Health Education. The manual can help school administrators, especially principals, plan and carry out programs for staff health. A free copy of the manual is available from Health Insurance Association of America, 1850 K St. NW, Washington, D.C. 20006.

The Seaside Story:

An Interview on Staff Wellness

Len Tritsch, Oregon health education leader, has been conducting health promotion activities on the state level and helping districts since 1977. Here, he explains how to plan and carry out inservice health promotion activities for teachers and other staff members.

Q: How did you arrive at the original concept for the Seaside conferences?

Tritsch: We looked at the research that had been done on ways to get people to alter their behavior and attitudes. Then I took a long look at how to give people confidence in bringing about change in a community. I look on a school as a community. I also recognized that the team concept was going to be important so that participants could feed off one another's energy and form a support group.

Q: How do you teach participants what they need to know?

Tritsch: You get the participants to say what they want, what they need, and expect to achieve. Then they sign a contract to do it.

Q: Do you recommend that outside specialists conduct local staff wellness programs?

Tritsch: Outside instructors may be necessary to get the program started and carry on inservice activities, but otherwise personnel from within the district can run them.

Q: What are the most effective arguments to persuade administrators to get behind staff health promotion?

Tritsch: I ask them to take a look at teacher absenteeism, teacher morale, and teacher effectiveness. Teachers who are physically fit are more effective in the classroom because they have more energy.

Q: Do you talk to administrators about student needs?

Tritsch: Not at this point. In Oregon, we are just now moving into curriculum after seven or eight years of working with staff only.

Q: Why are some administrators reluctant to get into staff wellness?

Tritsch: Some are defensive about their own health behavior. They know we're strong on modeling, and they may think their own health habits are not for modeling. Second, they think it's going to cost too much money. Third, some don't look on health as being a real basic, like reading and writing.

Q: How do you get around defensiveness by both teachers and administrators?

Tritsch: We depend on communication—being able to sit down and talk about the importance of health. True, some of the teacher unions are still concerned about this; so, this means more talking, more explaining.

Q: Do health promotion activities require board policy changes?

Tritsch: It varies. Some districts have board policies about teachers exercising on school time.

Q: Do most districts permit that?

Tritsch: Again, it varies with the district. Sometimes this is controversial. Some districts absolutely say no and others say, "Well, let's give it a try. If it works, we'll continue it."

Q: If the board does not permit teachers to exercise on school time, does that fact make a difference for staff participation?

Tritsch: There may be more teachers who will get involved if they do it on school time. We have some exercise programs, though, for teachers that get going at 6:30 a.m. The thing that's most important is that your program be developed so that there's mutual support among staff, so that people work together.

Q: Are boards in Oregon supporting your ideas and approach?

Tritsch: Boards are moving more in that direction. They are using staff development money to do it, but they are also saving money in the process. I'm thinking of the number of people coming to Seaside each summer. A lot of districts want to send 30 or 40 people; so, they see great returns for a small investment.

Q: What should an administrator do to convince the board with regard to this program?

Tritsch: When the superintendent comes before the board, the best arguments to bring are those about dollars and cents.

Q: Are there any objections to using gyms, classroom space, and similar school facilities for staff wellness?

Tritsch: We haven't run into that at all.

Q: How much lead time does a district need between the time it starts staff health promotion and the time it starts health curriculum implementation?

Tritsch: You need a minimum of two years to work on wellness for the staff, because it takes that long to get them hooked on it.

The Seaside Story: *(continued)*

Q: How would you start on staff health promotion?

Tritsch: The first thing I'd do is have a one- to three-hour session to introduce the concept of staff wellness or health promotion. Attendance at the initial meeting should be mandatory for all district or school staff members so that they get a feel for it. Then they can decide if they want to take part or not.

Q: Who leads this session?

Tritsch: You need a resource person to explain what wellness is all about. Doing this takes about 10 percent of my time, but many state departments don't provide this kind of help. There are other resources within most states, however, to help start and carry on teacher wellness activities. Volunteer agency staff are one possibility. If I were a superintendent, I'd call my state department of education and find out if someone there knows of possible resource people. You may have to pay a fee that might run from $50 to $300 for a speaker. Some Oregon districts pay up to $1,500 for a resource person.

Q: Then what?

Tritsch: I would do a survey to determine what a district needs and wants with regard to teacher wellness. Staff in a district that already has, say aerobics, may want to consider other areas, such as nutrition. Then I'd appoint a wellness coordinator who has the power to make decisions at the administrative level. This person doesn't have to be a health expert. He or she facilitates and coordinates the program. The experts are the people who do the inservice.

Q: What comes after the survey?

Tritsch: You need to take a look at the best delivery system to meet the needs. Would one-hour sessions be adequate? Three half-day workshops during the year? Continuing education courses? If you're going to deal mostly with information, then one-hour sessions might be fine. But if you're going to get into skill development and changing attitudes, that won't be enough.

Q: What about costs?

Tritsch: You can do it for zero dollars if you want to use people from volunteer agencies and state departments, or you can use staff development money. The cost of various instructors for a three-credit inservice course might run up to $3,000 to $5,000. A college professor might charge an honorarium of $200 to $400. Some colleges are moving into this area. It's getting so that there's so much expertise in some Oregon districts that school system employees can do many of the things themselves.

Q: What else must be in the budget?

Tritsch: Money for books to stock a professional library, books for the teachers' lounge, a place to exercise, and some equipment—blood pressure cuffs and stethoscopes, for example.

Q: Do teachers pay part of the costs for staff programs?

Tritsch: In a lot of districts teachers pay, say, two to four dollars apiece to get an instructor to lead aerobics class. I think it's a good idea.

Q: What should a superintendent's role be?

Tritsch: They have to demonstrate that they are interested in the health of their teachers and other staff members. And if it's good for staff, it's good for administrators. An administrator's biggest mistake is not to get involved.

Chapter 11

Budget

Paying for a modern, comprehensive health program—What the regular school district budget can do—And how, surprisingly, business, industry, professional, and civic groups can help

Will a modernized and enhanced health education and promotion program require more money than your district now spends? Possibly, but not so much more as to cause any superintendent to shy away.

How *much* more will depend on

- How adequate your present outlays are for health education and promotion
- The level of improvement to which you and your school board wish to commit themselves
- The timeline over which you wish to spread improvements
- The energy your staff gives to the task of seeking financial and other support from outside sources.

School expenditures for health are now splintered, scattered, and spread over several budgetary items. This is the situation in the majority of districts and it is a situation that makes it difficult to find a bottom line for health or even to make a reasonable estimate.

Perhaps this is, as one superintendent put it, "the nature of the beast." But it is nevertheless useful to look at the several aspects of health expenditures and to get some concept of the whole.

Two questions are worth asking: What are we now spending for all phases of health? What should we spend to get an improved health education program that will meet the needs of the community for the next several years?

Some preliminary worksheet exercises may be useful, as district budget committees and fiscal experts take on these questions.

To get such exercises going, we present a sample worksheet to set down the best estimates as to what you are spending now and your expectations for what you would budget in the near future to meet the needs of your district. Not all items will apply to all districts, and not all items need carry budgetary allocations (a school health committee, for example, may not require extra outlays unless it takes on research or needs-study projects calling for some outlay of money).

The figures that business and fiscal officials put down in the first column ("What We Are Spending Now") should raise questions for discussion at board meetings and community advisory committees. Are the expenditures adequate?

Sample Budget Worksheet

Components for Health	What We Are Spending Now Dates:	What We Can Budget For Dates:
Textbooks (by grades or levels)		
_____		
_____		
Other print material (by grades or levels)		
_____		
_____		
Audiovisual resources		
Development of curriculum guides		
**		
New-type comprehensive health programs		
Elementary		
Secondary		
**		
Evaluation of health programs		
**		
Health coordinator(s)		
Health teachers (secondary grades)		
Teacher training		
Consultant fees		
**		
School health committees		
Community advisory committee		
**		
Nursing services		
School physician		
Other medical and psychiatric services		
**		
"Sick" rooms		
Health-related supplies, equipment, and facilities		
**		
Staff wellness programs		
**		
Safety inventories		
Safety improvements		
Beautification of plant and grounds		

Are they promoting the health of students and staff?

The figures called for in the second column ("What We Can Budget For") are starting points for planning, for assessing community sentiment for health promotion, and for determining the degree of effort the district wants to make for the future.

Getting Outside Money and Support

A decade ago, many school districts counted on getting federal help to launch health education programs. Now that source is drying up. Nevertheless, local district administrators can often find outside financial help, but they have to look harder for it.

There still *is* a lot of money "out there" for health education, although the quest for this support may take educators into new fundraising tracks and into new experiences.

Let's first look at a unique venture.

New York City's experience with the New York Academy of Medicine illustrates how successful a school project can be if it can muster local donors behind health education. The academy's support has enabled several schools in New York City to adopt the School Health Curriculum Project. The academy also helped involve other groups. In 1982, at least 37 other organizations were contributing time, resources, or money to keep the health education program going.

The guiding force behind the effort was the academy's Committee on Health Education. John V. Waller, committee chairman, became convinced that the New York schools badly needed better health education. "Problems of family life planted seeds of behavior disruptive to health. I was convinced this could be turned around by introducing a health education program in the schools," he said, explaining his personal commitment to the program.

Since then, the demonstration program has spread to many additional schools. In 1984, New York City allocated $1.3 million (over three years) for this purpose, and private support has continued as well. Donors have included the American Cancer Society, Bankers Trust Company, Metropolitan Life Foundation, Morgan Guaranty, the New York Community Trust, the New York Lung Association, and the Queensboro Lung Association. Annual fundraising galas help fill the program's coffers, too.

While the New York City venture may not be easy to replicate, some of its lessons may be useful for districts large and small. And the biggest lesson is that help can be found from many groups and many sources.

Applying this lesson means

- Searching for help from private industry
- Searching for help from professional and volunteer agencies
- Searching for help from foundations
- Searching for help from government agencies other than the school district.

Planning Gets the Dollars

If you would reach out for financial assistance (and other types of aid) from beyond your district's school budget, plan, plan, plan. Know what you're going after. Think through what kind of health program you want to create; why the district needs it; at which points, and for what components, you need help—and how much.

Help from Public and Nonpublic Sources

The state education agency is a good place to start. Search for state funds for health promotion and not only those labeled for education. State funds for public health, mental health, social services, highway safety, substance abuse—can these be tapped for the school curriculum effort?

While you work with your state agency, develop your own list of potential contributors, and make it long. In addition to local health agencies, it might include business and professional groups, fraternal and social organizations, official education and health agencies (state and local), Blue Cross/Blue Shield and other insurance companies, philanthropic organizations and individual philanthropists, colleges and universities, citizens' committees and parent groups, not-for-profit organizations, United Funds, and hospitals and professional health service groups. No group with an interest in preventive health, fitness, nutrition, or safety should be overlooked. Local government groups should be contacted, too—not just the health department, but the local fire, police, recreation, and social services departments.

Doing the Legwork

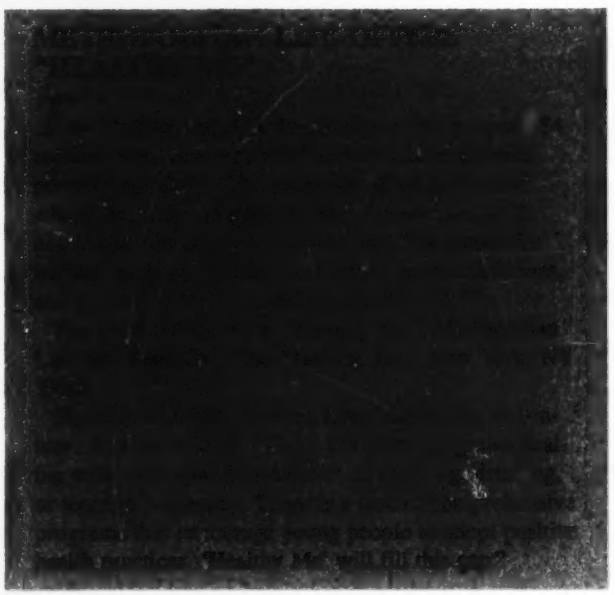
Running down leads about potential donors will take time and legwork—good reasons for appointing a full-time health coordinator. An Office of Disease Prevention and Health Promotion publication, *Locating Funds for Health Promotion Projects*, suggest that fundraisers learn as much as possible about potential donors. Advance homework is important. Before making a formal contact, find out if the organization currently has funds available. What are its priorities and eligibility requirements? How should proposals be submitted?

For further information about *Locating Funds for Health Promotion Projects*, contact the Office of Disease Prevention and Health Promotion, Mary E. Switzer Bldg., Room 2132, 330 C St. SW, Washington, D.C. 20201.

Public libraries can help by providing lists of companies that award grants for various purposes, and large regional libraries may have staff to help dig up other reference material on fundraising. To get a line on foundation funding, educators might try a publication called the *Foundation Directory*. This book, published by The Foundation Center (888 Seventh Ave., New York, NY 10106), lists 4,000 foundations that award 90 percent of the foundation dollars given out in the nation and describes each foundation's areas of interest.

Finally, even though federal money is tight at present, new money becomes available for health promotion from time to time. Publications such as *The Commerce Business Daily*, the *Catalogue of Federal Education Assistance Programs*, the *Catalogue of Federal Domestic Assistance*, and *Public Health Service Profiles of Financial Assistance Programs* are worth reviewing on a regular basis.

Despite these possibilities, administrators should always bear in mind that nothing can take the place of local district support. Local interest and community commitment will determine whether a health education program fails or succeeds. Success, in turn, depends on whether the program meets genuine local needs.



Chapter 12

Evaluation

Assessing instructional efforts on behalf of student health—Long-range evaluations and what they conclude—State of the art

The unexamined—or unevaluated—curriculum may not be worth teaching. Fortunately, evaluation of major health education programs shows not only the worth of certain types of health curricula but also the characteristics of successful programs.

Let's look at some research evidence.

A massive study by Abt Associates in Cambridge, Massachusetts, traces how health instruction affected 30,000 students in grades four through seven in 73 school districts throughout the U.S. From spring 1981 to January 1985, evaluators documented and analyzed how four different health education curricula, including the School Health Curriculum project, affected students in different districts.

Evaluators explored several crucial questions about health education: How much instructional time does it take to make a real difference? How important is teacher training? What is the comparative value of a comprehensive program, as opposed to one that concentrates on a specific area, drug abuse or smoking, for example, or on a few areas? How does a program's cost relate to its effect?

"The study shows, in general," says the first volume of the Abt evaluation report, "that health education works; that it works better when there is more of it, and that it works best when it is implemented with broad-scale administrative and pedagogic support for teacher training, integrated materials, and continuity across grade levels. It works best also when there is attention to the building of foundations of basic health knowledge, rather than starting with categorical health problems later in the academic career of pupils."

Besides the School Health Curriculum Project, evaluators looked at three other programs that have been taught in elementary school classrooms long enough to show an impact on students:

- The *Health Education Curriculum Guide*, developed by the Stark County, Ohio, United Way Health Foundation
- *Project Prevention*, created by Oregon curriculum developers
- *Reading, 'Riting, 'Rithmetic and High Blood Pressure*, a heart health curriculum sponsored by the Georgia affiliate of the American Heart Association.

Results from Major Studies

The evaluators found that all four curricula significantly affected the health knowledge, attitudes, and behavior of students. For example, evaluators turned up evidence that student smoking was delayed because of their health instruction.

Other findings of the Abt study include:

- Although all the curricula benefited the students, those exposed to comprehensive programs, rather than those that dealt with a specific health topic, showed the most improvement.
- In classrooms where students were taught the complete version of a curriculum, covering all the material it contained, the program was most likely to influence student attitudes and behavior toward health.
- Teacher training was important to the success of health education; and so was providing sufficient time, materials, and resources for health education instruction. "Programs that required training and provided specific program support materials achieved more uniform and complete implementation," evaluators report.
- Parent participation made a real difference in the way that students felt and acted about their health.

Other findings of the study deal with the amount of time that should be set aside for health education to make a real impact on students and comparisons of the effectiveness of the various curricula relative to costs.

When completed, the Abt study's final report will run to six volumes. For more information, contact Robert Gold, Office of Disease Prevention and Health Promotion, 2132 Switzer Bldg., 330 C St. SW, Washington, D.C. 20201.

Additional new information about how health education affects what students think and do about health comes from a study that has been going on for more than five years under the auspices of the American Lung Association in New York City. During this time, researchers Richard L. Andrews and Jill T. Hearne, University of Washington, Seattle, have been looking for indications that children who study the Primary Grades Health Curriculum Project (kindergarten through grade three) and the School Health Curriculum Project (grades four through six) behave differently, in terms of health risks, than children in a control group, who take a more traditional school health education program or children who study only the School Health Curriculum Project in the middle grades. The researchers intend to follow these children for several additional years.

At the sixth grade level, the evaluators verified five hypotheses:

- Sixth graders who were exposed to the entire comprehensive curriculum (kindergarten through grade six) scored higher when tested on knowledge of good health, body systems, and the effects of smoking than children in the control group.
- Sixth graders exposed to the comprehensive curriculum scored higher on tests measuring health attitudes than the other students.
- Sixth graders exposed to the comprehensive curriculum demonstrated higher levels of control over their own health than the other children.
- Sixth graders exposed to the comprehensive program experimented less often with tobacco, alcohol, marijuana, and other dangerous drugs than the other students.

Designing Local Studies

Not only the findings but the design for research used in the Abt and Andrews/Hearne studies will be of value to local districts when these two major studies issue their final reports. The design for research may offer clues (and patterns) for evaluating local health education programs. And evaluation of health education at the local level is crucially important. Without evaluation there will be no way to know that a program is meeting its objectives, no grounds for justifying its expense to parents and the communnity, and no certainty about how it might be improved. Evaluation will cost money—perhaps as much as 5 percent of the total amount spent on all health activities. The budget should anticipate expenses for buying measurement instruments, scoring answer sheets, and hiring consultants.

Here is what health experts and school administrators say about evaluation when it is carried on in a district:

Evaluation should be wide-ranging. In Michigan, where evaluation is an important part of the state plan to help districts develop comprehensive health education, evaluators will be studying not only how the new programs affect students but also how teachers, administrators, and parents feel about the things that are happening. Each program component will be evaluated, including inservice training. Michigan teachers, for example, will keep logs of their experiences as one means of reporting back to the state education agency.

Gathering the Right Data

Evaluators usually collect two types of information as they set out to determine a program's effectiveness. The first type measures *process*. Information is sought to answer such questions as: Is a program well-administered? Are staff members prepared for their responsibilities? Are resources adequate? Are instructional content, methods, and materials up-to-date and suitable for meeting program goals? A booklet prepared by the California State Department of Education, *Criteria for Evaluating the School Health Education Program*, advises local districts to look at these elements and also to consider whether the community, students, and parents are actively involved. (For more information on this booklet and on a companion document, *Criteria for Evaluating the School Health Services Program*, contact the State Department of Education, 721 Capitol Mall, Sacramento, CA 95814.)

According to the California booklet, a well administered program:

- Has a written statement of the district's policy regarding health education
- Has a curriculum consistent with the current state health instructional framework (is up-to-date, sets grade level objectives, and outlines scope and sequence)
- defines responsibilities for all people involved—principals, teachers, school nurses, any others.

An Oregon department of education survey form used by schools to assess their health education capacities asks districts to determine, among other things, whether elementary school teachers have as much training in health education as in mathematics, science, and reading and whether secondary health classes attract an equitable share of enrolled students.

Evaluating Program Effects

The second kind of information that evaluators gather measures outcomes. It seeks answers to a big question. Has the program increased student knowledge about health or changed their attitudes or behavior toward health risks? In this type of evaluation, tests are keyed to program objectives, and test makers take care that questions cover comprehensive health topics, in the same sense that the health curriculum itself is comprehensive. Evaluators also search for indices of success. Have student absences dropped? Are there fewer cases of communicable diseases in the schools? Have students become visibly more enthusiastic about health since the program started?

Several states are showing interest in assessing health knowledge as a part of their statewide testing programs. Until recently, health questions have not appeared on either state competency tests or college entrance examinations, and many health educators felt this was one of the main reasons that health education wasn't taken more seriously in schools. Starting during fall 1985, students in Michigan have the option of taking a health test as part of their regular state testing

program, along with the compulsory testing in reading and math. The state has also developed a health knowledge test for local districts.

Student knowledge is only one indicator of health education effectiveness. Researchers have long been aware that simply knowing about the health risk of smoking, for example, does not necessarily keep youngsters from cigarettes. Peer pressure and the example set by parents often prove more influential than what a student learns in class. Consequently, health educators depend on strategies to modify the force of less beneficial social influences. Measuring whether these attempts succeed is important.

The final evidence of success—whether a program actually changes what students do—may not be apparent for several years after instruction takes place. For example, those who experience antismoking education from the time they enter kindergarten probably won't be ready to decide whether or not to smoke until they are in seventh or eighth grade. To finally prove or disprove a program's effectiveness, therefore, evaluators would have to measure student attitudes and behavior patterns before their health education began, and also follow them over the intervening years, maintaining, all the while, students' rights to confidentiality.

Looking at Single Topic Programs

Local evaluators have had few guides at their disposal for measuring attitude and behavior change. Measuring these elusive items can present difficulties even for skillful researchers.

Guides are available, however, for evaluating special health topics. Booklets for evaluating programs on physical fitness, diabetes, stress management, alcohol and substance abuse, smoking, nutrition, and immunization have been developed at the Centers for Disease Control in Atlanta. Each booklet deals with a single topic, and can be ordered from the National Technical Information Service, U.S. Department of Commerce, Springfield, VA 22161. Write first to find out about cost.

Educators can get free duplicates of the evaluation instruments used in long-term evaluation studies. These instruments measure student knowledge, attitudes, and behavior, chiefly with regard to smoking and alcohol education. For information about these materials, contact Richard L. Andrews, M-219 Miller Hall, DQ-12, University of Washington, Seattle, WA 98195, or the American Lung Association, 1740 Broadway, New York, NY 10019. Further help will come from a practical guide for evaluating health education developed at the Northwest Regional Educational Laboratory in Portland, Oregon, under contract to the Office of Disease Prevention and Health Promotion. The guide, titled *How Healthy Is Your School?*, covers evaluation of the school environment and the health services program and includes a discussion of literature in the field. (For information about the guide, contact the laboratory at 300 South Sixth Ave., Portland, OR 97204).

AIDS—DEALING WITH THE FACTS AND THE FEARS

Schools were gripped with serious health issues during the mid-1980s. First, schools were confronted with herpes. Fears the disease would spread within schools caused some schools to exclude students and staff with the disease. Both inclusion and exclusion were controversial. School administrators faced confrontation between individual rights and the public health.

When schools opened for the 1985–86 school year, the concern was AIDS, Acquired Immune Deficiency Syndrome, a fatal disease that attacks the immune system of its victims. At first, medical experts were quite sure the disease was spread only by sexual contact and only among certain groups within the population. Later discoveries of the virus in body fluids caused doubts about how the disease was transmitted.

On August 28, 1985, the Centers for Disease Control in Atlanta released guidelines for enrolling students with AIDS. Those guidelines indicated that, except in rare cases, AIDS victims should be admitted to classes.

"None of the identified cases of HTLV-3 LAV (AIDS) have been transmitted in school, day-care, or foster care settings," the Center reported. Brown University Medical School specialists, after a special study, and several state and county health officials, came to the same conclusion. The American Academy of Pediatrics also supported this view.

What seemed to be changing facts caused fear levels to rise. The tension between individual rights and concerns about the public health rose swiftly. Superintendents in Kokomo, Indiana, and New Haven, Connecticut, were firm: no child having AIDS, or suspected of having the disease, would be admitted to school. School authorities in Swansea, Massachusetts, and Los Angeles, California, decided to admit AIDS victims to classes, unless special risks, on an individual basis, would lead a physician to forbid it.

The New York City schools decided to admit students with AIDS. However, the identity of those students would be withheld. In Queens, parents responded with an angry, if short-lived, boycott of the public schools. The schools were facing two diseases: AIDS and fear.

This AASA Critical Issues Report is devoted to health promotion and health education, not to the solution of all school or student health problems. However, concerns about AIDS and any similar disease affect everyone connected with schools. Ultimately, the superintendent must deal with the concerns of all those people.

What's Happening in Some States

This state-level advisory came from the Connecticut State Department of Education in March of 1985. "All children have a constitutional right to a free, suitable public school education. . . . Children with AIDS should be allowed to attend a regular classroom, with approval of the child's physician, and should be eligible for all rights and services provided by law." In the state of New Jersey, a panel of medical experts has been established to make a determination for the Commissioner of Education as to whether or not a child with AIDS will enter school, when conflicting positions are held at the local level. Specifically, a conflict would exist if the school board medical examiner and the child's physician do not concur on whether the child should be admitted to the school.

Superintendent Ray Kelly of Bergen County, New Jersey, has strongly endorsed use of the panel. Kelly, who oversees 75 local school districts, has a deep interest in school health problems. He says:

> We have to look at the AIDS issue calmly. Against a national school population of 36 million, we have had reported 180 cases of AIDS among school children as of October 1985. Not one was the result of a school environment. Our main problem as school superintendents is to stress such facts and seek to reduce the fears of parents. AIDS, where it occurs, is first and foremost a health problem for the family to tackle with the help of a family physician and with state and local public health officials.
>
> It becomes an educational problem when the question of exclusion comes into the picture. Excluding a child from school is a serious matter and may violate the child's constitutional rights. As superintendents, we should move slowly on this point. Federal and state guidelines, the best medical opinion, and the recommendations of special panels must all be considered. And we must have ample authoritative information for the community and for parents, who, properly, have deep concerns about the issue.

Note: Federal guidelines for schools enrolling children with AIDS were released by the Centers for Disease Control in Atlanta on August 28, 1985. Those guidelines are available from the Centers for Disease Control, 1600 Clifton Road NE, Atlanta, GA 30333, or from your state or local health officials or state education agency. The guidelines are not included in this book since modifications could take place over time.

Assessing Staff Health

Administrators may find that evaluating staff wellness activities is simpler than evaluating programs for students. *Wellness at the School Worksite* (see Chapter 10, p. 58) outlines a scheme that local districts can use to gauge the short term effects of a program. The authors recommend that evaluators focus on short range goals at first, because it might be years before a program pays off in terms of fewer heart attacks or less lung cancer among school employees.

As a first step for measuring a program's cost-effectiveness, the booklet says, districts should collect figures on present sick care costs, including payments for workers compensation, social security disability, and health insurance over a five-year period. Then, as they keep track of changes in these costs after staff wellness activities start, the savings will be obvious. Other factors that evaluators might look at as they attempt to weigh a staff wellness program include:

- How many employees stick with the program
- Growth in employees' knowledge about wellness
- The number of employees who meet the goals they have set for themselves—losing weight or stopping smoking, for example
- Staff absences before the program started, compared to what happens afterward
- Number of accidents and claims for disabilities or medical care
- Changes in productivity
- Changes in food or cigarette consumption
- Subjective changes in employees' attitudes or morale.

A MESSAGE FROM THE U.S. OFFICE OF DISEASE PREVENTION AND HEALTH PROMOTION

On the occasion of the publication of this *Critical Issues Report*, I would like to congratulate the American Association of School Administrators (AASA) for the significant achievement this landmark document represents. It is fitting that we pause to recognize the association's longstanding commitment to the health of school age children. For those in the field of health education, this tradition of involvement is perhaps best portrayed by the significant commitment and contribution of Forrest E. Conner, who served as executive secretary of the AASA from 1963 to 1971. We are all indebted to Conner for his role during the conduct of the national School Health Education Study, the most comprehensive effort of testing school age children in any subject field until the late 1960s. His support of that study, and the support of AASA and its affiliates, helped make that historic study possible.

Today, factors that shape our lifestyles and our environment play a dominant role in our health status. We feel strongly that the nation's schools provide an appropriate and efficient medium for educating our children about the increasingly complex risks to health and about the ways in which individuals and society can control those risks.

Nonetheless, we encounter many barriers to the extensive and effective implementation of school-based health promotion and disease prevention programs. There needs to be some clarity about the federal role in improving implementation efforts, about the role of our education agencies in health issues, and about the systematic coordination of efforts to produce the measurable benefits we think result from health education programming in the schools.

I am sure you will agree that this *Critical Issues Report* provides an informative overview of both the problems and the prospects for school health education, and it is with that in mind that we applaud your efforts. We recognize that the content and conduct of education is a local issue. It is therefore important that you, the educational decision maker, make a commitment not unlike the earlier contributions of Forrest E. Conner and others at AASA. Certainly the intent and outcome of this report is ample tribute to their endeavors on behalf of health education.

J. Michael McGinnis
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